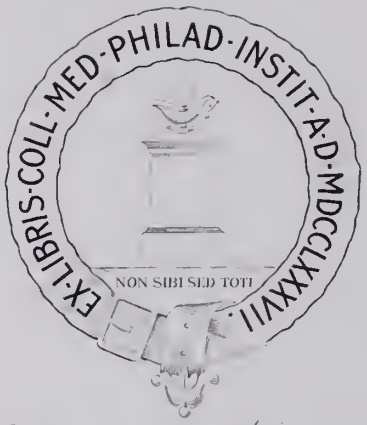
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JANUARY 1967 • VOLUME 65 • NUMBER 1

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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Ken-Bar Inn, Gilbertsville


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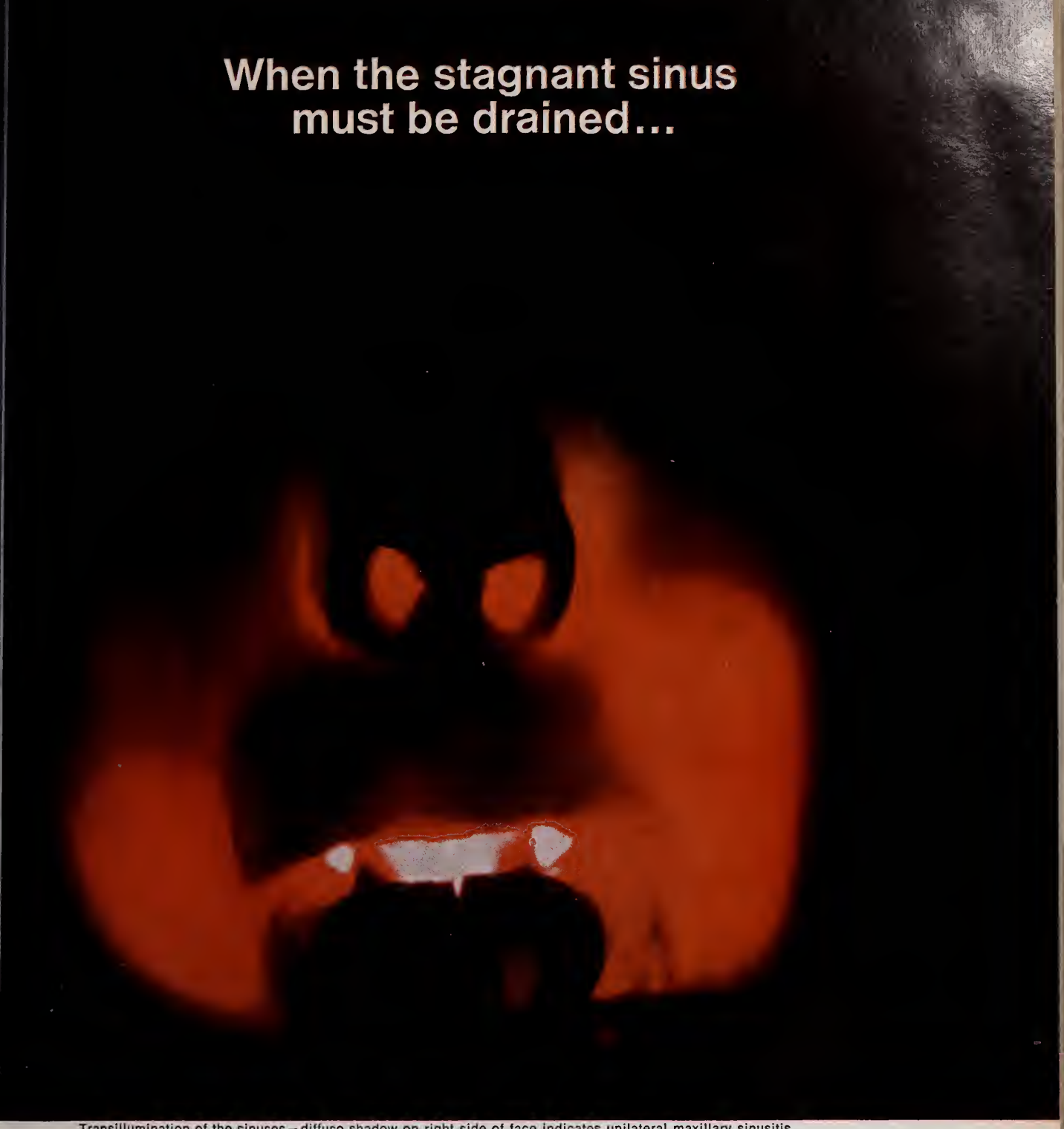
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When the stagnant sinus must be drained...



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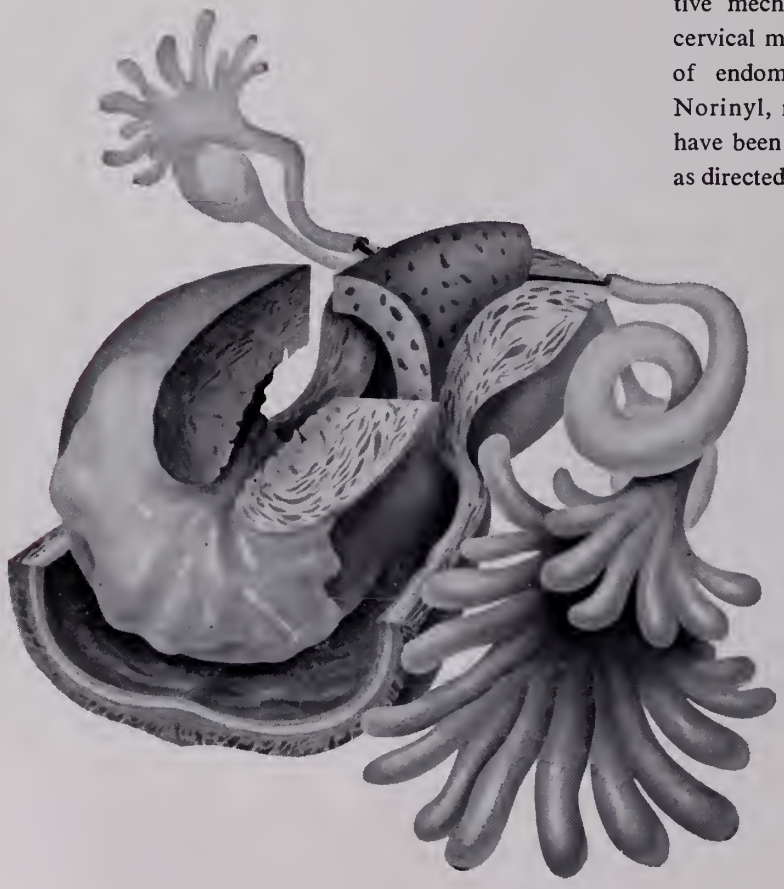
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inhibition of ovulation by means of 2 time-proved hormonal agents

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Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

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An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.
Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.
Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.
Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.
NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.
Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)
Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, O. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, O. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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MESSAGE FROM THE PRESIDENT



Community Service, A Challenge to Work Together*

WE are moving into the last third of the twentieth century, and find rapid and serious changes taking place in our husband's profession. Our goal as auxiliary members is to make the helping hands of the doctor's wife reflect and enrich the physicians dedicated service to mankind. This year with permission of our advisory committee, great emphasis will be given to community service, health careers, AMA-ERF, and Legislation. Selecting of these four by no means preludes our other valuable projects, for they too are very important.

Time and events draw the pattern for our work. We must accept the challenge to work and plan for community efforts which will solve local problems at local levels.

In working for good health through service we will be cooperating with other groups. These include, the medical societies, to whom each local auxiliary must look for guidance, other health organizations, and charitable organizations. Most of these groups are interested in health programs and we can work with them effectively in our communities.

Doctors' wives must have a challenge, and as members of the Woman's Auxiliary to the Kentucky Medical Association each one is willing to seek a challenge, acquire accurate up-to-date information, and make a contribution to the community and to her fellow man.

MRS. RAYMOND E. JONES, PRESIDENT
WOMAN'S AUXILIARY TO THE KMA

This is the first of a series of articles written at the request of KMA President Robert E. Pennington, M.D., by the president of the Woman's Auxiliary to KMA and the three KMA vice-presidents.

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Emotional disturbances (moderate to severe)	●		
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Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
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Tetanus	●	●	

'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information In SK&F literature or *PDR*. *Contraindications:* Comatose states or the presence of large amounts of C.N.S. depressants. *Precautions:* Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. *Side Effects:* Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

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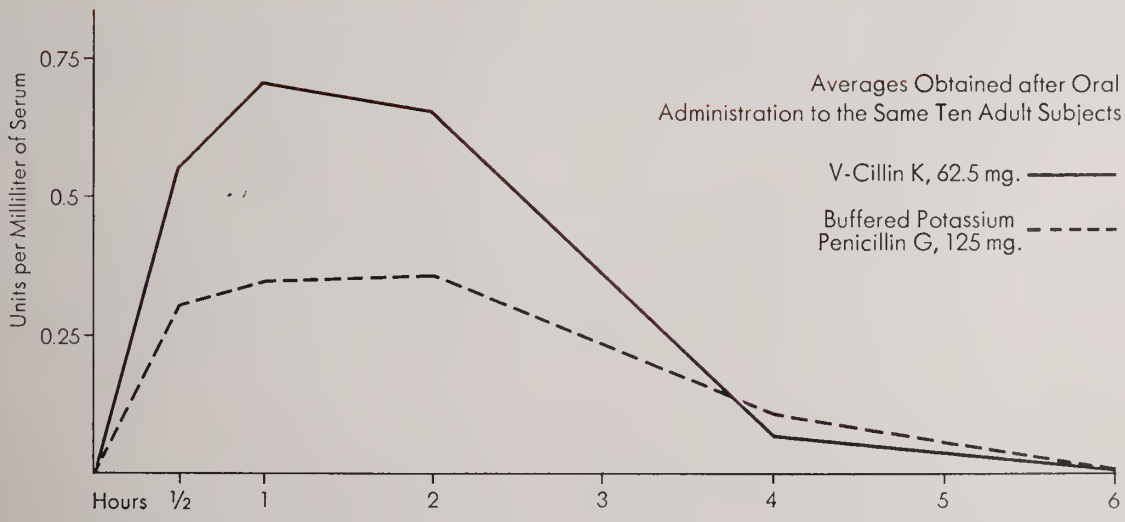
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Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269 1019, 1963.

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Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

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Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penic hypersensitivity reactions occur, the drug should be discontinue

Adverse Reactions: Although serious allergic reactions are less common with administration of oral penicillin than with intra lar forms, skin rash, symptoms resembling those of serum sickne other manifestations of penicillin allergy may occur. When penic administered, measures for treating anaphylaxis should be r available. Those include epinephrine, oxygen, and pressor dr relief of immediate allergic manifestations as well as antihista and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the growth of antibiotic-resistant organisms; in such a case, antibio ministration should be stopped and appropriate measures taken

Administration and Dosage: For Tablets V-Cillin K and for V K, Pediatric, the usual dosage ranges from 125 mg. (200,000 three times a day to 500 mg. (800,000 units) every four hours. I fants, the daily dosage may be 50 mg. per Kg. of body weight d into three doses.

Beta-hemolytic streptococcus infections without associated b remia may be treated with 200,000 to 400,000 units three times Therapy should be continued for a minimum of ten days to preve velopment of rheumatic fever and/or other serious complication age for routine streptococcus prophylaxis in patients with a his rheumatic fever or congenital heart disease may be 200,000 units or twice daily. When such patients undergo tonsillectomy, tooth e tion, or other minor surgery, the prophylactic dose should be 5 units every six hours given two days prior to surgery and for two postoperatively. If oral medication is not feasible on the day s gery, parenteral therapy should be considered. Mild to mode severe pneumococcus pneumonia has been treated effectivel 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be every six to eight hours in conjunction with indicated surgical dures.

For gonorrhea in males, 500 mg. (800,000 units) every six ho three doses may be employed; in females, 500 mg. every four ho six doses are recommended. Patients with a suspected lesion of s should have a dark-field examination before receiving penicill monthly serologic tests for a minimum of three months.

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V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 uni 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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IN THE BOOKS

ARTERIOGRAPHY, PRINCIPLES AND TECHNIQUES: by Joseph L. Curry, M.D. and Willard J. Howland, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1966; 328 Pages; Price, $14.00.

The purpose of this monograph, written by two radiologists engaged in private practice in a community hospital, is to provide a brief introduction to the field of arteriography for radiologists and other physicians who feel the need of initiating such procedures in their hospitals. The material in the text is based on several years experience by the authors in a community hospital. It represents the gradual evolution of technique and the recognition of various problems as they were encountered in over 1200 arteriographic procedures.

Since this text is written primarily for radiologists and other physicians who have had no previous experience in arteriography, the authors discuss in great detail about the essential equipment and materials needed in performing proper arteriographic procedures. The different arteriographic techniques are carefully described. These include percutaneous and retrograde pressure arteriography, selective arteriography and translumbar aortography. The inherent hazards in each procedure and possible sensitivity to contrast material are also emphasized.

Of special appeal in this book are the thorough exposition—yet brevity of discussion—and multiple illustrations. X-ray reproductions are clear. The place of arteriography in evaluation of each disorder is discussed, together with demonstration of the lesion in several projections. For information or more advanced and complex arteriographic procedures, the readers are referred to works by well recognized authorities in the field.

J. T. Ling M.D.

OCULAR PHARMACOLOGY: by William H. Havener, M.D.; Published by C. V. Mosby Co., St. Louis, 1966; 448 pages; Priced $21.75.

This is a very well written volume which admirably fulfills its purpose of providing as up-to-date information as possible on virtually all ophthalmic drugs. The author has succeeded in providing the proper balance between the basic science of pharmacology and practical therapeutic considerations, resulting in a book which is not only interesting to read, but should be of great help to the ophthalmic practitioner in his daily work.

Some of the more interesting chapters are those on anesthetics, antibiotics, antiviral agents and corticosteroids. The mechanisms of action and proper indications for these agents are poorly understood by most ophthalmologists and perhaps other physicians as well, so that a wide gap in our general knowledge is filled by these sections. The chapters on antibiotics and antiviral agents are remarkably up-to-date and provide a rational method of approach to therapy.

This book has an extensive bibliography and most of the statements made are well substantiated by reference to recent research. Only rarely does the author resort to personal experience with a few cases, and then only when some controversy exists in the literature.

Every ophthalmologist should have this book in his library, as well as anyone else particularly interested in the various aspects of pharmacology and practical therapy.

Robert J. Kaiser, M.D.

HEMATOLOGIC PROBLEMS IN THE NEWBORN: by Frank A. Oski, M.D. and J. Lawrence Naiman, M. D.; Published by W. B. Saunders Company, Philadelphia and London, 1966; 294 Pages; Price, $11.00.

This concise monograph dealing with the hematologic disorders arising soon after birth should prove to be of interest to all physicians involved with management of the neonate.

The first two chapters outline the normal blood values during the newborn period and the abnormal potentialities of the maternal-fetal relationship. Chapter three serves as an excellent review of the types of anemia in the neonate and offers a rational approach to differential diagnosis. Following are chapters dealing with red cell and hemoglobin metabolism, management of erythroblastosis fetalis (including up-to-date, but necessarily skimpy, discussions of intrauterine intraperitoneal transfusions and prevention of Rh antibody formation by use of anti-D gamma globulin) and coagulation problems. Final chapters in the book concern the thrombopenias and leukocyte disorders of infancy.

The text is very readable—the book being liberally sprinkled with effective tables and charts. The bibliography is adequate, if not exhaustive. This book should serve as a valuable adjunct to the more comprehensive hematology texts such as Dr. Carl Smith's classic, Blood Diseases of Infancy and Childhood.

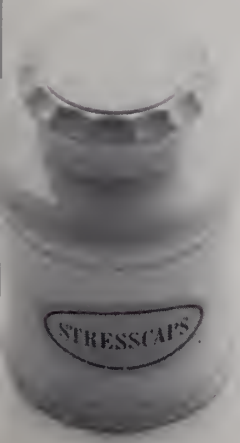
Leonard E. Reisman, M.D.

(Continued on page 22)



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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

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clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

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A clinical cure rate of 97.7%

Case Reports on File, Dept. Clin. Development, Abbott Laboratories.

Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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SYNOPSIS OF NEUROLOGY: by Francis M. Forster, M.D.; Published by C. V. Mosby Company, Saint Louis, 1966; 218 Pages; Price $7.50.

This is the second edition to this little volume which portends to "present to the medical students the methodologies used in making an evaluation of the neurologic patient and to acquaint him with the most significant features of the disease entities in the field of neurology" (the words of the author). This it does not do (the words are mine).

As if the above were not pretentious enough Dr. Forster says that ". . . it (the book) will also be of value as a refresher to the family physician and to the physician who is specializing in fields removed from clinical neurology". As an educator I resent the talking down to the "average" physician or the lowly medical student. Their potentials are as great, if not greater, than the "specialist" (even neurologist?).

The contents of the journal is indeed a nosological compendium of what the author refers to as the "neurologist's neurologies" (again his words) which usually means a rehash of stew which has been long a-simmering yet not reached synaptic maturation.

The undersigned has searched long to find what the needs of the medical students might be in basic clinical neurologic education. This volume, by its very nature, would seem to foster mediocrity such as similar journals in other fields, e.g. Merck's Manual. Hence there would seem to be no need for it.

However, even H. L. Mencken (a fellow native Baltimorean of another heyday) would always seek out the story, or, bluntly put—what is the moral—what is the lesson to be learned. This I believe, is best stated in the author's own words in referring to the importance of the neurologic history. He says "competent neurologists expect by way of the history to arrive at a reasonable differential diagnosis. . . Most neurologists, when the history leaves them at sea, are extremely uncomfortable about the possibility of being unable to arrive at an adequate and competent diagnosis even after the detailed examination". As my neighbor would judiciously say, "Man, dems my feelins egsactly". But—five and one-half pages—2½%, is devoted to this subject. My case rests!

EPHRAIM ROSEMAN, M.D.

I believe that, rather than summarily removing a useful drug from the market, it is better to rely upon the trained and intelligent judgement of the practicing physician. In the event that a drug has undesirable properties which are not commonly known, dissemination of information concerning those properties through channels such as *The Journal* or other medical publications is a far more sensible method of handling the problem.—George C. Manning, M.D., in *Journal of the American Medical Association,* (197:61), July 4, 1966.

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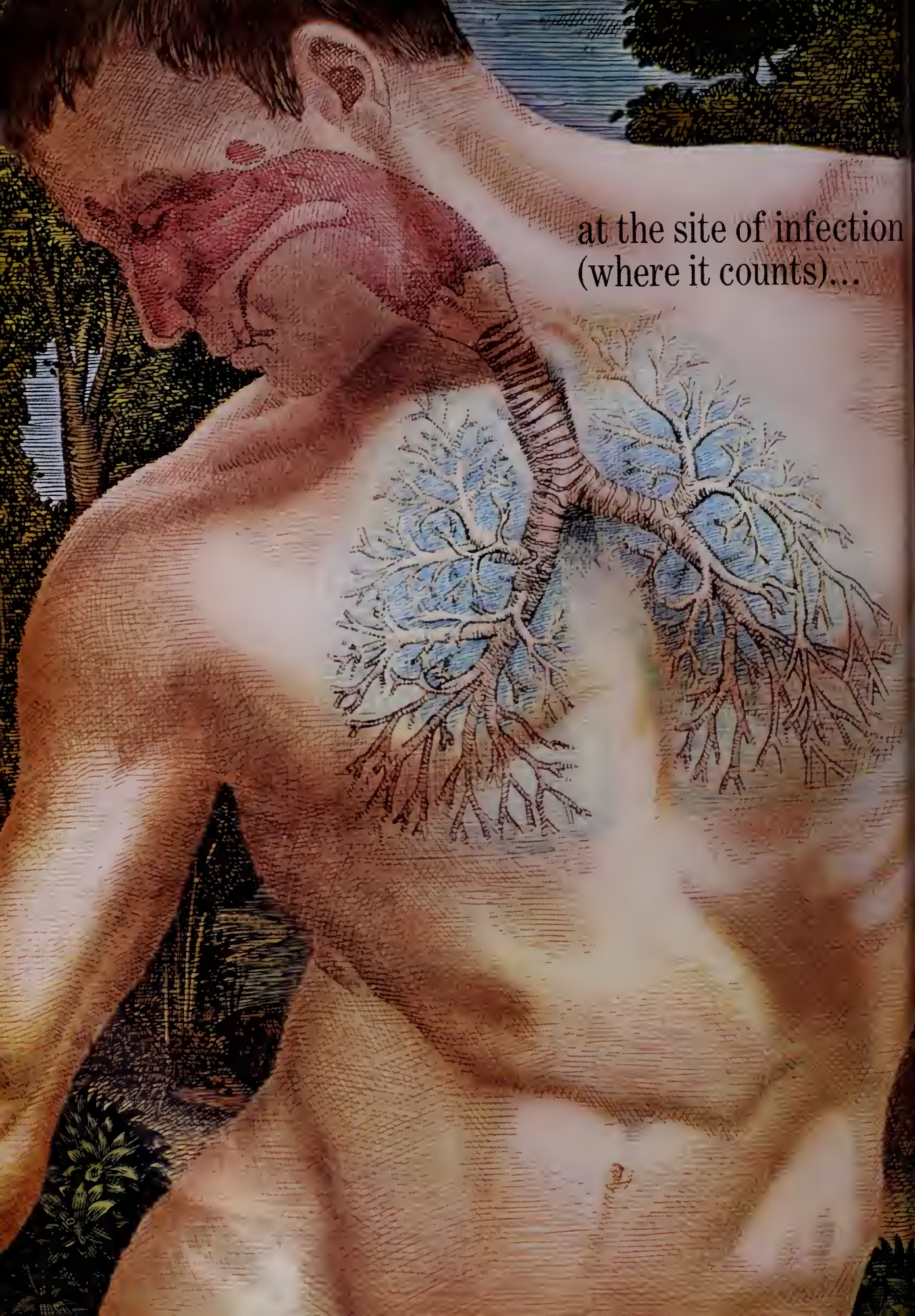
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In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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(See next page for prescribing information.)

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Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory finding characterized by increased direct-reacting bilirubin, el alkaline phosphatase levels, negative or weakly positive ce flocculation and thymol turbidity tests, elevated serum gl oxalacetic transaminase levels, peripheral eosinophilia, ar mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice h been reported in other patients taking prolonged courses medication. Patients with chronic infection have been giv to 2 Gm. of the drug daily for periods of two to six montl patients with rheumatic fever have taken prophylactic d 0.5 Gm. daily for two years without difficulty. In one gr 144 patients who received the drug daily for two years, n dice was noted. It was of interest that members of six o patients' families, who were not taking the drug, had e of jaundice during the study period.

Transaminase and serum alkaline phosphatase level determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mon rheumatic fever prophylaxis. The results were compare those of a similar group of forty-four patients who receiv icillin. There were no cases of jaundice in either group. El of SGPT and serum alkaline phosphatase levels during the of treatment was observed in one patient treated with and in two patients treated with penicillin. Seven other p in the group receiving Ilosone and four others in the pe group showed elevations in one of the tests at some time administration of the drugs.

Very satisfactory therapeutic results, without toxicity reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients wer parable to those in a similar control group who had r penicillin.

Gastro-intestinal disturbances not associated with hepa fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alim tract; however, the normal intestinal gram-negative ba flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with of erythromycin, there have been occasional reports of urt skin eruptions, and, on rare occasions, anaphylaxis.

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Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds weight, the usual dosage is 5 mg. per pound every six hou children twenty-five to fifty pounds, 125 mg. every six (Tablets Ilosone Chewable should be chewed or crush swallowed with water.)

For adults and for children over fifty pounds, the usual of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythr therapy should be considered.

In the treatment of syphilis, the recommended total do 20 to 30 Gm. given in divided doses for a period of ten to days. Close follow-up of the patient is necessary since e mycin drugs have not had adequate evaluation in all st syphilis. Examinations of spinal fluid are recommended of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four da recommended. In the treatment of gonorrhea, patients suspected lesion of syphilis should have a dark-field exam before receiving antibiotics, and monthly serologic tests be made for a period of three months.

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Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equ to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pa

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:3
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198

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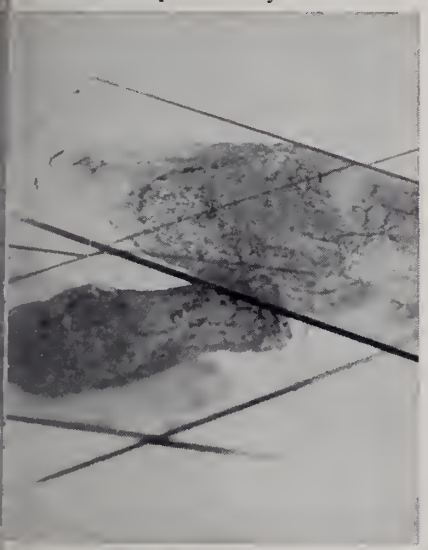
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Pacemaker Therapy in Complete Heart Block: Current Concepts of Management

Gordon K. Danielson, M.D., Lester R. Bryant, M.D., John W. Bowlin, M.D. and William G. Malette, M.D.*

Over the past five years, electrical pacing of the heart has dramatically changed the outlook for patients with complete heart block. Current pacemakers are effective and relatively safe even in elderly or seriously ill patients.

ACQUIRED complete heart block is a very serious abnormality which carries a high mortality. Although a few patients will survive for many years, the average duration of life after detection of this arrhythmia is only 26 months.[1] In addition to the high mortality of untreated heart block, considerable morbidity may result from severely reduced activity and congestive heart failure as a consequence of the slow cardiac rate and decreased cardiac output. Furthermore, episodes of cardiac asystole or transient ventricular tachyarrhythmias produce impairment of cerebral circulation and Stokes-Adams attacks in over 50% of patients with third degree heart block.[1,2,3] In one series, persistent 2:1 heart block had a similar incidence of syncopal attacks.[2] Once Stokes-Adams attacks appear, the prognosis for patients with heart block worsens, and 50% are dead within one year.[3]

Numerous drugs have been employed to control complete heart block, but these have been generally unsatisfactory. The sympathomimetic amines ephedrine, adrenaline, and isoproterenol have been used for many years with some benefit. Epinephrine and isoproterenol are perhaps more beneficial in patients with heart block when used intravenously for the temporary control of cardiac arrhythmias and syncopal attacks. Cortisone, atropine, thiazides, and numerous other medications have occasionally been helpful.

A new oral sustained-action isoproterenol has been employed with greater success than previous agents, but the side effects may be troublesome, and long-term control is difficult in a majority of patients. Dack[4] reports that approximately half of his patients with Stokes-Adams attacks who were carried on long-term medication developed recurrent seizures, often fatal, within six to twelve months after discharge from the hospital. Bluestone and Harris[5] also found a very high failure rate when treating heart block with long-acting

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isoproterenol. Furthermore, in seven of their 75 patients, this drug was thought to have caused the patient's death by inducing prolonged episodes of arrhythmias.

Such experiences would indicate that drug therapy probably should be abandoned promptly in favor of an implanted pacemaker if there has been incomplete success in controlling the Stokes-Adams attacks.

Electrical Pacemakers

Rapid developments in electrical pacing of the heart over the past five years have dramatically changed the outlook for patients with complete heart block. Stimulation of the heart with an electrical current passed through the patient by electrodes strapped to his chest was first performed by Zoll[6] in 1952. This method requires relatively large voltages and causes painful muscular contractions. Although uncomfortable to the patient, it is still applicable in emergency situations for temporary pacing of the heart.

The first clinical application of electrical stimulation of the heart by means of a catheter electrode inserted through a peripheral vein and into the right ventricle under fluoroscopic guidance was made by Furman and Schwedel[7] in 1959. Parsonnet et al.[8] and Goetz[9] modified the technique by introducing a bipolar catheter electrode, thus eliminating the need for a separate ground electrode inserted beneath the skin. The bipolar electrode and external generator box provide a rapid and safe therapy for heart block and have the advantages of easy control of rate, amplitude, and duration of cardiac stimulation. Long-term treatment with an external pulse generator, however, has been generally unsatisfactory because of troublesome complications of infection and displacement of the electrode tip.

Percutaneous insertion of electrode wires directly into the heart[10] can be useful as an emergency measure, but this technique is not without some technical difficulties of electrode placement and the possible complication of bleeding from the myocardium or a coronary vessel. In addition, it is unsatisfactory for long-term pacing because of wire breakage and the development of infection.

The introduction of totally implanted pacemakers with cardiac electrodes by Chardack,[11] Zoll,[12] Kantrowitz,[13] and others has been a definite advance over external methods for long-term cardiac pacing. A thoracic incision is necessary for placement of the electrodes directly on the myocardium (Fig. 1). The electrode wires are led subcutaneously to the pulse generator which is placed in an abdominal or lateral thoracic subcutaneous or subfascial pocket. Such totally implanted units have been extensively employed for the treatment of symptomatic heart block, and, in general, they have been quite successful. However, they do necessitate general anesthesia and a thoracotomy, so their application in the elderly or seriously ill patient must be carefully considered.

Recently developed units combining an endocardial electrode catheter with a totally implanted pulse generator (Fig. 2) are simple, effective, and relatively safe, particularly for the older patient with heart block.[14,15,16] The bipolar endocardial catheter is inserted down the right external or internal jugular vein and wedged in the right ventricular cavity under cinefluoroscopic guidance. The distal end of this catheter is led subcutaneously to the generator box which is implanted beneath the skin or muscle of the upper anterior thoracic wall (Figs. 3,4). The whole procedure has the distinct advantage that it may be performed under local anesthesia, and the possible complications of thrombosis and infection have not been frequent or troublesome. This technique is gaining in popularity both in this country and abroad.[14,16,17]

Other types of pacemakers have been developed including variable rate units[18] and pacemakers stimulated by the P-wave of atrial electrical activity.[19] Because of the greater complexity of these units and the consequent greater probability of mechanical failure, they are not employed for routine implantations. Fixed-rate pacemakers have proven entirely satisfactory in the majority of patients with heart block in the older age groups. Variable rate and synchronous pacemakers have distinct advantages for younger patients who lead active lives, and they are also useful for patients undergoing major cardiovascular surgery when an increased cardiac output is necessary in the postoperative period.

Numerous experimental pacemakers have been developed such as those powered by the motion of the heart or great vessels[20] and those whose batteries may be recharged through the intact skin.[21] Such models offer



FIGURE 1. Myocardial electrodes in place on the left ventricle.

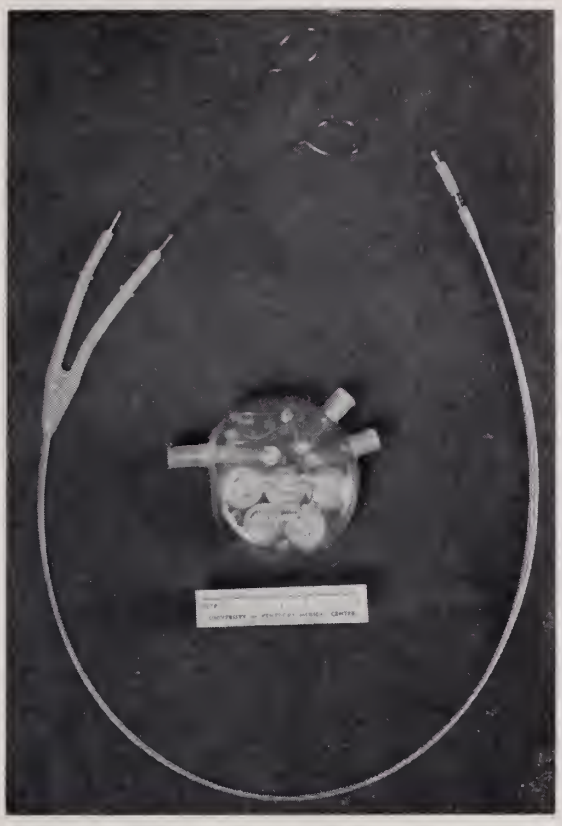


FIGURE 2. The Chardack endocardial electrode and pulse generator. Stylets are removed following proper placement of the electrode in the right ventricle.



FIGURE 3. Cervical and pectoral incisions for the Chardack endocardial pacemaker.



FIGURE 4. Totally implanted endocardial pacemaker system with electrode in apex of the right ventricle. Broken wires from previous pacemaker visable over apex of heart.

exciting possibilities, but they have not been sufficiently developed and proven for general clinical use.

Indications for Pacemaker Implantation

The chief indication for implantation of a pacemaker in a patient with either permanent or intermittent complete heart block is the occurrence of syncopal episodes. One Stokes-Adams attack is enough to consider seriously insertion of a pacemaker, and failure of the patient to respond to medical therapy with consequent repeated attacks should be considered an urgent indication for operation.

Additional indications for implantation of cardiac pacemakers are consequences of a low cardiac output. Intractable congestive failure, markedly restricted exercise tolerance, reduced cerebral and renal function, and angina pectoris are usually greatly improved following restitution of a normal cardiac rate.

The increasing success of pacemakers and the decreasing mortality and morbidity of implanting them have liberalized indications for operation. Our group and others[22] have observed sudden deaths in patients with heart block who were otherwise without symptoms. This experience prompts us to recommend pacemaker implantation in any patient with persistent complete heart block who does not respond to medical therapy, even though he has not yet demonstrated a Stokes-Adams attack.

Fortunately, age is no contraindication to surgery as most patients who develop heart block are between 60 and 90 years of age. Indeed, these patients may tolerate their slow cardiac rate less well because of occlusive vascular disease in vital organs. For this reason they are often even more urgently in need of pacemaker assistance.

Current Management of the Patient

Upon admission to the hospital, a patient with complete heart block is placed in an intensive care unit where the electrical activity of his heart is continuously monitored. A defibrillator and external pacemaker are kept nearby at all times, and routine laboratory tests including an electrocardiogram and a chest x-ray are obtained. The medical work-up is begun with particular emphasis directed to possible causes of the heart block.

An effort is made to determine whether the patient has suffered an acute myocardial infarction, as this may influence the choice of therapy. Thoracotomy with implantation of electrodes directly on the myocardium is definitely contraindicated in a patient with an acute infarction because of the hazards of anesthesia and surgery. Opinion is divided on the advisability of transvenous pacing in patients with heart block secondary to acute myocardial infarction. Dack,[4] for example, recommends medical treatment with isoproterenol and steroids because heart block is usually transient in patients who survive an acute infarction. Others,[23] however, have found temporary pacemakers life-saving in this group of patients.

The patient's response to drug therapy usually is determined during his initial evaluation, and the advisability of a pacemaker is discussed. At the present time, almost all symptomatic patients are considered for implantation of some type of permanent pacemaker.

A temporary transvenous cardiac pacer electrode is passed through an arm vein prior to the insertion of a permanent pacemaker to assure complete control of the heart rate before and during operation. This may be performed immediately prior to insertion of the permanent endocardial electrode, but is done preferably several days in advance of a thoracotomy.

Since the temporary transvenous catheter electrode removes the necessity of urgent surgery, patients with heart block may be optimally prepared for their definitive procedure. Increasing the cardiac rate to 65 to 75 beats per minute increases cardiac output and improves blood flow to the heart, brain, and kidneys. Frequently this is all that is needed to clear the patient of congestive heart failure, although improvement is hastened when digitalis and diuretics are added. Treatment of associated diseases such as chronic pulmonary infection and renal insufficiency may be done in an unhurried fashion. Patients are maintained on antibiotic therapy while temporary transvenous catheter electrodes are in place, but anticoagulation is not necessary.

At the present time, we favor implantation of a permanent endocardial pacemaker unit for the older patient and for those with severe

concomitant disease of other organ systems. The endocardial system is also particularly useful for treating patients in whom cardiac pacing from a previously implanted pacemaker has been interrupted by wire breakage. This avoids a second thoracotomy which may prove troublesome in a previously dissected area. The unit is easily installed under local anesthesia with cinefluoroscopic guidance, and patients may ambulate and eat on the evening of operation. They are usually discharged from the hospital after two or three days of continuous monitoring when it is certain that the heart is following the pacemaker well. In accord with the same philosophy we hold regarding prosthetic cardiac valves, all carious and abscessed teeth are removed prior to operation to prevent bacteremia and infection of the catheter which lies within the blood stream. A short course of antibiotics is given immediately before and after implantation of the unit, but the patients are not maintained on antibiotics or anticoagulants.

For younger patients, a system of permanent myocardial electrodes connected to a pulse generator implanted in the lateral thoracic wall still appears to be the preferable pacemaker arrangement. The risk of general anesthesia and thoracotomy is negligible in selected patients, and the additional stability of cardiac electrodes would seem to be advantageous. We currently prefer a fixed rate unit which has Elgiloy leads.* Elgiloy alloy has been shown to have a durability five to 200 times greater than other electrode materials,[24] and since many early pacemaker failures were due to fracture of electrode wires, the Elgiloy leads should extend the longevity of totally implanted units. A synchronous version of this pacemaker which responds to atrial P-waves** provides improved hemodynamic function of the heart and adjusts to the varying needs of the very active patient. [25]

Clinical Experience

Between November 1962 and July 1966, 24 patients have been treated with a totally implanted cardiac pacemaker at the University of Kentucky Medical Center. The 15 units implanted prior to January, 1966 were of the Electrodyne type.*** Since January, a Chardack endocardial pacemaker**** has been used in 11 patients, three of whom had previous Electrodyne units which failed. Another patient, a 28 year old professional baseball player, developed complete heart block secondary to severe calcific aortic stenosis and was treated with a General Electric dual-rate pacemaker.***** This pacemaker was installed at the time of excision and replacement of the damaged aortic valve with a Starr-Edwards prosthesis. With this unit, a cardiac rate of either 68 or 85 beats per minute may be selected using a magnetized control rod placed briefly on the skin over the generator box. The uneventful convalescence of this patient was due in part to the fact that his heart could be paced at the faster rate during the immediate postoperative period when an increased cardiac output was necessary.

The ages of the patients ranged from 28 to 83 years, with a median age of 70. In the last six months, with the exception of the patient with aortic stenosis described above, the youngest patient was a man of 60 years with severe pulmonary disease, and the oldest was 83 years. This accounts for the recent predominant use of the endocardial pacemaker which is the unit of choice for the older or seriously ill patient.

The cardiac rhythm on admission for most patients was complete heart block with a ventricular rate which ranged from 22 to 54 beats per minute. Stokes-Adams attacks occurring in this group were found to be due either to bouts of asystole or to runs of ventricular tachyarrhythmias. Three patients had a predominant cardiac rhythm of second degree heart block with 2:1 conduction, and two patients had a first degree heart block with a right bundle branch block. In these two groups, Stokes-Adams attacks developed when there was a sudden shift to complete heart block, usually associated with a period of asystole.

Symptoms bringing the patient to the hos-

*Ventricor model, Cordis Corporation, Miami, Florida.

**Atricor model, Cordis Corporation, Miami, Florida.

***Model TR-14, Electrodyne Company, Inc., Westwood, Mass.

****Model 5870-C/5816, Medtronic, Inc., Minneapolis, Minn.

*****Model A2070AA, General Electric Company, Milwaukee, Wisc.

pital were usually related to Stokes-Adams attacks—dizziness, light-headedness, fainting, and convulsions. However, seven patients were hospitalized primarily because of complications of a chronic low cardiac output. These patients complained of edema of the lower extremities, severe shortness of breath, and inability to carry out their daily activities. Five also had experienced one or more episodes of dizziness or syncope. Two patients had angina, and in one it was the predominant complaint. The duration of symptoms prior to admission ranged from one day to six years.

Complications (Table)

Two very ill patients with advanced heart failure died in the hospital subsequent to a thoracotomy for pacemaker implantation. While neither death could be attributed to pacemaker failure, this type of patient would now be treated with a permanent endocardial unit to avoid the risks of anesthesia and thoracic surgery. Two late deaths occurred three and sixteen months following operation. One pacemaker was known to be functioning at the time the patient died of other causes, and the second patient died suddenly in her sleep.

The major complication was electrode failure which occurred seven times in six patients. This was seen as early as five months and as late as 40 months after implantation. Wire breakage was located almost always at the site of placement of the electrode in the myocardium. Reoperation was necessary in each case for reimplantation of the electrode or replacement of the entire unit. No instance of electrode failure has occurred in the more recent series of endocardial pacemakers.

Meticulous attention to aseptic operative technique has been rewarding in that no infections have developed in any patient. It also is gratifying that there have been no late infections, particularly in the endocardial pacemaker series.

Contractions of the diaphragm due to phrenic nerve stimulation by the cardiac electrodes have occurred in two patients. This was not troublesome in one, but in the other it necessitated left phrenic nerve crush through a small cervical incision. Diaphragmatic contractions in a third patient were noted at the time of implantation of the electrodes. These

TABLE

Complications of Implanted Pacemakers

24 Patients. 1962-1966

	Electrodyne (15)	Chordack Endocardiol (11)	General Electric (1)
Deaths			
Hospital	2	0	0
Late	2	0	0
Electrode Failure	7	0	0
Generator Failure	1	0	0
Infection	0	0	0
Phrenic Nerve Stimulation	2	1	0
Migration of Electrode	0	3	0
Currently Functioning	8	11	1

disappeared when the phernic nerve was insulated by placing a layer of fat between the heart and pericardium. No instance of phrenic nerve stimulation has occurred since adopting the procedure of covering the electrodes with an Ivalon plastic patch. Unexplained diaphragmatic stimulation is also present in one patient who has an endocardial electrode, but the contractions are mild and the patient is aware of them only when he is inactive.

Electrode displacement has been the most frequently encountered difficulty with the Chardack endocardial pacemaker. This has developed as early as one week and as late as four months after pacemaker implantation. In one patient, the electrode has advanced into the pericardium over the left ventricle where it continues to stimulate the heart effectively. In two others, the generator box rotated or migrated laterally and pulled the catheter back into the right atrium where it failed to pace the heart. In one of these patients, pacing became ineffective again without obvious change in position of the catheter, necessitating two attempts at replacement before the heart would consistently follow the pacemaker. Fortunately, the electrode catheter could be repositioned in all cases by reopening the original incision under local anesthesia.

These early experiences with the endocardial catheter have prompted some revisions in the technique of implantation. In addition to fixation to the external jugular vein, the catheter is further secured in the neck with a number of non-absorbable sutures. Similarly, the pulse generator in the chest wall is securely anchored to prevent migration and rotation. For greater stability, it may be placed under the pectoralis major fascia or wrapped in a

Teflon net which then becomes firmly enmeshed in fibrous tissue. It is hoped that these measures of implantation and fixation will prevent the problem of late displacement of the pulse generator and endocardial catheter. In all other respects, this pacemaker system has been entirely satisfactory.

Several patients have had intermittent heart block with conduction of their own atrial impulses. Theoretically, if the electrical stimulus of the pacemaker is strong enough and falls in the vulnerable period of the preceding conducted beat, there is a possibility of producing ventricular fibrillation, particularly in the anoxic or irritable heart.[26] However, the amplitude and duration of the pacemaker impulses appear to be below the fibrillation threshold, as the competing arrhythmias have been well tolerated in all patients. There was only one unexplained sudden death, and this occurred in a patient who was not having conducted atrial impulses. If pacemaker induced repetitive firing should prove to be a problem during temporary transvenous pacing, the use of an implantable standby pacemaker should prevent further dangerous arrhythmias.[27] This unit will not compete with naturally occurring conducted beats and will turn itself off in the event that regular sinus rhythm returns.

The pacemaker failure rate of our earlier series compares with other reports in which 30 to 50% of patients have required reoperation.[4,22,28] All of our patients are now being paced satisfactorily, and no mortality has resulted from reoperation. New developments in materials, electrode designs, and methods of implantation should improve the longevity of current pacemaker models.

Results

Results have been uniformly good, particularly in the prevention of Stokes-Adams attacks. In several patients in whom complete heart block was associated with runs of ventricular tachycardia or fibrillation, no further episodes have occurred once a dominant rate was established by the implanted pacemaker. Patients have also reported that their activity has been greatly increased, and several remarked they did not realize how incapacitated they had been. The individual who had a pacemaker implanted because of angina associated with a slow cardiac rate is greatly improved and now takes only an occasional nitroglycerin tablet. The subjective improvement these patients have experienced is reflected in their willingness to undergo surgery again when pacemaker difficulties have developed.

Summary

Rapid developments in electrical pacing of the heart over the past five years have dramatically changed the outlook for patients with complete heart block. Although pacemakers are susceptible to mechanical failure, new modifications should greatly improve the durability and longevity of current pacemaker units. A recently introduced endocardial pacemaker catheter with totally implanted pulse generator has proven to be simple, effective and relatively safe and is now the pacemaker of choice for most patients.

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(Continued on page 102)

Elevated Alkaline Phosphatase Levels In Multiple Myeloma: Fact Or Fiction

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One hundred cases of multiple myeloma were reviewed and only one case was found to have a very minimally increased level of alkaline phosphatase in the absence of specific accompanying pathology.

IN ORDER to revise certain misconceptions concerning alkaline phosphate levels in multiple myeloma, the following data will be presented in what I hope will be a short and yet accurate discussion. Whether the above mentioned misconceptions be widespread or localized, I think that the facts which follow will be of use to all who diagnose and treat this disease.

Brief Review of the Literature

Whenever statistics are quoted concerning alkaline phosphatase levels in myeloma, the article of Adams et al. (1) is always referred to since it was the first large study performed. Having no argument with any of its authors, I should like to say that they stated in their title that electrophoretic patterns were their main interest in this disease. It therefore comes as no surprise that the article passingly states that a) the alkaline phosphatase levels (in Bodansky units) were greater than 4u in 10 of 21 cases (48%), and b) the highest value obtained was 26.5u with an average of 5.2 Bodansky units. If one takes the time to read this article it is apparent that no clinical or individual features are otherwise recorded; no study in depth was recorded or even attempted when alkaline phosphatase levels were discussed. As a matter of historical fact, it was just prior to this time, in 1947, that Urethane was first noted to be of some use in myeloma (2) and the use of this drug may have played a role in the elevated levels obtained (purely a supposition of mine).

In 1953, Snapper et al (3) stated that, "The alkaline phosphatase is usually normal in multiple myeloma although Adams, Alling and Lawrence reported an elevation above normal in 48% of their cases. In our series 71 of 86 patients (83%) had repeated values within normal limits. The other patients, most of whom had large fractures, had elevations at one time or another. Only 5 patients had serum alkaline phosphatase levels of more than 16 K-A units, but 2 of these had normal values on subsequent determinations, and a third had cirrhosis of the liver. Although rare exceptions exist as noted, when the serum alkaline phosphatase remains elevated in the absence of a gross pathologic fracture or of liver disease, the diagnosis of multiple myeloma should be questioned."

In 1958, (4) 73 patients with myeloma were studied by Martin and Sculthorpe, for alkaline phosphatase levels by means of the K-A method and "only one exceeded the absolute upper limits" of their normal adult range and "only 3 fell outside the usually accepted limits."

In a recent CPC (5) the statement was made with reference to this point that "a modest elevation in approximately a fourth of the cases" of myeloma is seen at the Massachusetts General Hospital, and in 1965, Dillman and Silverstein (6) recorded elevations from 14.4 to 33.6 K-A units in 14 of 107 patients (13.1%) with most in a range between 15 and 20 K-A units. Three of the 14 were found to have amyloid disease.

Observations

With the above in mind, 100 consecutive cases of multiple myeloma were reviewed (these patients were seen between 1954 and 1964). Twelve of these cases were found to have elevated values of alkaline phosphatase at one time or another, but the circumstances surrounding these elevations are quite interest-

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ing and will be discussed.*

These 12 cases were subdivided into clinical classifications for simplification:

GROUP 1
DRUG-INDUCED ELEVATIONS: 6 PATIENTS

A. URETHANE:

PT. 1—

This patient was treated at another hospital with Urethane and on a subsequent admission to the Brookdale Hospital he was found to have alkaline phosphatase levels of 12 and 13 SJR units. Upon discontinuation of the drug, normal levels were then noted (5 SJR units).

PT. 2—

Levels of 9 and 8 SJR units were noted prior to Urethane treatment. Subsequent values were 20u, 26u, 30u, and 24u, with bilirubin levels of 4mgm% (total).

PT. 3—

Levels of 7.5u, 7u and 7.7u (K-A) were present prior to Urethane treatment. After 5 months of this therapy, the alkaline phosphatase levels rose to 13.9 K-A units and six months later it was 20 K-A units, a value obtained just prior to death.

PT. 4—

Urethane was found to have caused levels of 3u, 4u, and 4u (SJR) to become elevated to 10u just prior to death.

B. THORAZINE:

PT. 5—

Values of 7u and 10u (K-A) were followed by levels of 15u and 11u after a total dose of 110mgm of Thorazine was given. The levels subsequently diminished to 4u, but Thorazine was re-instituted and after an additional 475mgm was given over a short period of time, the alkaline phosphatase levels rose to 15u, 15u and 11.7u. The patient subsequently died and at autopsy, the liver was found to be normal.

C. COMBINATIONS OF DRUGS:

PT. 6—

Levels of 6u and 4u rose to 13u (SJR) after combined treatment with Urethane, Thorazine and Compazine.

GROUP 2
SERUM HEPATITIS: 2 PATIENTS

PT. 7—

Alkaline phosphatase levels of 9u, 3u and 11u (K-A) were elevated to 15u and 14u during an admission for serum hepatitis.

PT. 8—

This patient was admitted with levels of 53u and 35u (K-A) associated with bilirubins of up to 25-mgm% total. These elevations followed blood transfusions for severe anemia noted on a prior admission.

GROUP 3
MISCELLANEOUS: 4 PATIENTS

A. PLASMA CELL LEUKEMIA:

PT. 9—

Level of 5 SJR units rose to 11u just prior to death. This patient had plasma cell leukemia—no autopsy was obtained.

B. INTRAHEPATIC DISEASE OF UNKNOWN ORIGIN:

PT. 10—

Alkaline phosphatase levels of 14.9, 3.0 and 11.7 K-A u. were noted during the patients hospital stay. The original level which was slightly elevated returned to normal levels at the time of her death. An autopsy was performed and the liver showed "infiltration with atypical plasma cells in periportal areas with cholestasis."

C. RECENT FRACTURE:

PT. 11—

This patient was admitted with an alkaline phosphatase level of 18.2 K-A units associated with a recent fracture of the axial skeleton and severe bone pain. Subsequent values 6 months later showed levels of 8.3 and 7.7 K-A units.

D. MULTIPLE MYELOMA AND PAGET'S DISEASE:

PT. 12—

This patient was admitted and found to have an alkaline phosphatase of 11 SJR units; x-ray indicated concomitant mycloma and Paget's disease. On bed rest, levels of between 4 and 7 SJR units were noted.

Discussion

As can be easily ascertained, it is quite unusual, if not rare, to have elevations of alkaline phosphatase levels which were not

The normal values prior to 1962 were 2-12 King Armstrong units; since that time the alkaline phosphatase levels have been performed using Shinowara-Jones-Rinehart units with the normals ranging from 2-9 SJR units.

due to any obvious underlying factor.

The effect of Urethane in causing hepatic toxicity is well known (7, 8) and explains the results found in cases 1-4 and case 6. Throazine "hypersensitivity" and its relation to intrahepatic cholestasis (9) has been known for some time; with this drug, jaundice and elevated alkaline phosphatase levels are seen with some frequency and were noted as the cause of the elevations seen in cases 5 and 6.

Serum hepatitis as the cause of the elevated levels seen in cases 7 and 8 is self explanatory as is the etiology in patient 12 who had Paget's disease involving several areas of bone.

The presence of a recent fracture (patient 11) suggests strongly that this was etiogically related to the abnormal values found.

The presence of intrahepatic cholestasis in patient 10 may very well have been associated with the transiently elevated value of 14.9 K-A unit although 2 subsequent determinations were within normal limits.

We therefore have at most one patient (patient 9) with elevated alkaline phosphatase levels in whom no definite cause can be found and in this case a very minimal and very transient elevation was present.

The inescapable conclusion is that elevated alkaline phosphatase levels are not seen in patients suffering from multiple myeloma; any elevated value must be interpreted only with the clinical features constantly in mind and the diagnosis of myeloma must be strongly doubted if this value is more than minimally elevated in the absence of obvious secondary factors. This conclusion coincides extremely well with that of Martin and Sculthorpe (4) as well as Snapper et al. (3) previously mentioned.

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Hypoprothrombinemic Hemopericardium In The Absence Of Organic Heart Disease

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Louisville, Ky.

Hemopericardium caused by hypoprothrombinemia, in the absence of organic heart disease, is a rare clinical entity. The case reported here had a near fatal cardiac tamponade but survived with pericardiocentesis and abandonment of anticoagulant therapy.

Report of a Case

A 47 year old white truck driver was admitted to the Norton Memorial Infirmary in August 1964 because of severe pitting edema to the nipple line. He had had intermittent swelling of the legs for the previous year, but the extensive unremitting anasarca had been present for only three weeks. On admission urinalysis, WBC and differential, serum potassium, chloride, CO_2, total protein and albumin globulin ratio, SGOT, alkaline and acid phosphatase, KUB film of the abdomen and electrocardiogram were all normal. The hemoglobin and serum sodium were depressed. The BUN was elevated and the chest film was normal except for a large hiatus hernia.

A diagnosis of obstructed inferior vena cava was made and when the patient failed to respond to intensive diuretic therapy, surgical exploration was performed. A transthoracic caval and bilateral deep femoral thrombectomy was done. No evidence of intra-abdominal carcinoma was found. Anticoagulation with heparin was started immediately after surgery. Diuresis occurred on the second postoperative day and three weeks later he was essentially edema free. Oral anticoagulation after discharge was maintained with phenindione.

In December 1964 he was readmitted for treatment of an anemia of 6.9 gm.%. WBC and differential, platelet count, urinalysis, BUN and total bilirubin were normal. The prothrombin time was 34 seconds with a control of 12 seconds. Reticulocyte count was 3.0%, stools were positive for blood, and the bone marrow revealed erythrocytic hyperplasia with no evidence of any blood dyscrasia. Complete gastrointestinal x-rays showed only the known large hiatus hernia. Because of his past history it was decided to repair the hiatus hernia rather than abandon long term anticoagulation. A hiatus hernioplasty, vagotomy and pyloroplasty were performed after several transfusions and he was discharged on phenindione, an ulcer diet and antacids.

In February 1965 he developed increasing dyspnea and was admitted in acute respiratory distress. The pulse rate was increased and paradoxical. The blood pressure was 94/80. Hemoglobin was 9.0 mg.% and a prothrombin time was increased beyond 100 seconds. Chest film revealed tremendous enlargement of the cardiac silhouette. Four whole blood transfusions and vitamin K_1 oxide were given immediately after admission with a shortening of the prothrombin time to 32 seconds. His condition, however, continued to be critical and on the evening of admission a pericardiocentesis was done. 300 cc of blood was removed and marked improvement was immediately observed. A second pericardiocentesis of 500 cc was done the following day. A third tap was dry. The patient was discharged on no medications and when last seen in June 1966 he was asymptomatic and performing light work.

Comment

It is well known that the incidence of hemopericardium, in patients with organic heart disease, increases with anticoagulation. In cases where the prothrombin time is prolonged beyond the usual therapeutic range the association becomes much more pronounced. However, bleeding into the pericardium in the absence of organic disease is extremely rare regardless of the degree of anticoagulation.

*Assistant Clinical Professor of Medicine, University of Louisville School of Medicine.

Barbour, Hirst, and Johns[1] reported on 105 cases of hemopericardium seen at autopsy. 63 cases were associated with acute myocardial infarction and 35 with ruptured aortic aneurysm. There was no case caused by anticoagulation alone.

Nichol[2] in 1950 reported 2 cases of hemopericardium without apparent organic heart disease. One was an elderly woman with cirrhosis and a fractured hip who was anticoagulated because of phlebitis. The prothrombin time became prolonged to 180 seconds, hemopericardium developed and death occurred. The second case was a 63 year old female who developed sudden arterial occlusion following a hysterectomy and auricular fibrillation. Anticoagulation was carried out with heparin and bishydroxycoumarin. In 48 hours the prothrombin time was unduly prolonged. A lumbar sympathetic alcohol block was also done. The patient died and autopsy showed retroperitoneal hemorrhage and hemopericardium.

More recently Fell, et. al.[3] reported 2 cases of hemopericardium which they felt were due to anticoagulation alone. It is interesting that one of their cases also had had a recent repair of a hiatus hernia as did the case reported here.

It is conceivable that some injury was done or a suture placed in the pericardium at the time of the hiatus hernia repair and that this produced a localized pericarditis that bled in the presence of hypoprothrombinemia. There was no history of heart disease in the case reported here and no abnormal physical or laboratory findings were observed until cardiac tamponade appeared.

Microscopic and gross hematuria, gastrointestinal bleeding, spontaneous ecchymosis, bleeding at the site of injury, hemopericardium associated with acute pericarditis and an increased incidence of myocardial rupture in acute myocardial infarctions are known hazards of anticoagulation. However, bleeding from a normal pericardium almost never occurs regardless of the degree of prolongation of the prothrombin time.

Summary

A case of hemopericardium due to hypoprothrombinemia in the absence of organic heart disease is reported.

Review of the literature reveals that this is an extremely rare clinical phenomenon.

Generic and Trade Names of Drugs

Phenindione—Hedulin
Bishydroxycoumarin—Dicumarol

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Transurethral Incision of the Vesical Neck

Edward H. Ray, Jr., M.D.

Lexington, Ky.

The author discusses his use of transurethral incision of the vesical neck for the relief of bladder neck obstruction in females and to overcome post-TUI contracture of the vesical neck in males.

FOR THE past four years I have performed transurethral incision (TUI) of the vesical neck for treatment of bladder neck obstruction in both women and female children and in contracture of the vesical neck in men. In 1961 Dr. Walter Keitzer described this procedure, which he had developed for the surgical relief of bladder neck contracture. 1-2. To perform transurethral incision of the vesical neck a urethratome with a sharp cutting blade was used to make incisions completely through the vesical neck at 12, 3, 6 and 9 o'clock in females and at 6 o'clock in males. In females the incisions were frequently carried the length of the urethra to overcome any distal urethra obstruction or stenosis of the urethral meatus. Dr. Keitzer felt that this gave adequate interruption of the circular fibers at the vesical neck, which were frequently very hard and fibrous, without the use of a cautery current and with very little tendency to recurrent contracture of the vesical neck which had been so commonplace when transurethral resection was carried out in this region.

Method

In the beginning I performed this procedure as described by Dr. Keitzer but was somewhat disappointed with the results. I felt that the incisions in the vesical neck were frequently not adequate when made in this manner and often, when complete healing had occurred, the vesical neck did not seem to have been appreciably enlarged. In addition, one child developed incontinence following a transurethral incision in which the incisions were made the entire length of the urethra and I am currently treating one other child who has become incontinent following transurethral incision of her vesical neck by someone else.

Because of these problems Dr. Keitzer's operation has been modified so that the incisions are limited to the vesical neck and instead of making them with the cutting blade of a urethratome, they are made with a high frequency disthermy current utilizing the Collings' knife electrode or a broken resectoscope loop which has been trimmed away except for one single straight wire. In this manner very deep incisions can be made into the vesical neck.

This procedure has been very effective in my experience and has been particularly effective in overcoming contracture of the vesical neck following transurethral resection of the prostate where dense scar tissue formation made repeat transurethral resections of the vesical neck of little permanent value and where open surgical procedures of considerable magnitude such as YV-plasty of the vesical neck have been required to obtain permanent relief.

Instead of the single incision at 6 o'clock, which Dr. Keitzer uses in male patients, I have endeavored to make incisions at each quadrant just as is done in females, although occasionally these may be made at points half way between the usual sites of 12, 3, 6 and 9 o'clock.

In addition to its use in the treatment of contractural of the vesical neck, I currently employ transurethral incision as a prophylactic measure at the time of transurethral resection of the prostate, especially in small fibrotic glands and median bar obstructions in an attempt to prevent the development of postoperative contracture of the vesical neck. The incidence of post-transurethral resection of vesical neck contracture is relatively low even without prophylactic incision of the vesical neck and I have not yet attempted to compare the incidence of its occurrence during the four years that this has been a routine procedure with that of the prior period during which it was not used. It is, however, my impression that the incidence of vesical neck contracture after transurethral resection of the prostate is

a good deal lower when these prophylactic incisions are made and in the last 500 transurethral resections in which they have been used, in not a single instance has bladder neck contracture, requiring surgical correction, occurred.

Results

During the past four years 10 men have been treated for post-operative contracture of the vesical neck in this manner and during the same time 37 female children and 19 women have been treated with transurethral incision of the vesical neck. There has been satisfactory relief of obstruction in all instances as evidenced by improvement in the urinary stream, relief of straining during micturition and reduction or elimination of residual urine where it had been present. It has not been possible to eradicate persistent or recurrent urinary tract infection in all instances. There has been, however, a tremendous improvement in even this problem. The majority of the children operated upon were seen originally because of persistent or recurrent urinary tract infection and in just over 90% of these infection has been completely eliminated.

Transurethral incision has been accompanied by no mortality and very little morbidity. Upon completion of the procedure a large indwelling catheter is put in and left for three days and in all instances the patient has been ready for dismissal from the hospital the day after the catheter was removed. In 4 women there was enough bleeding during the first to third post-operative week to be troublesome and in one of these an indwelling catheter was required to control bleeding. Fulguration, to control postoperative hemorrhage, was not required in a single instance. It requires approximately two to three months for the incisions in the vesical neck to heal completely and during this time all patients are maintained on some urinary antiseptic. Throughout this period there is very little discomfort in most instances and at the end cystoscopy reveals deep V-shaped incisions in the region of the vesical neck.

There have been no other complications to date and unless the incisions are carried too far distally in the female urethra, I can see no reason to expect incontinence to develop. There is, of course, the possibility that a vesicovaginal fistula could be created by making the cut at 6 o'clock too deep but if this is done carefully I see no reason to fear this.

Summary

Transurethral incision of the vesical neck seems a very safe and effective method of relieving vesical neck obstruction in the female and in treating contracture of the vesical neck in either the male or female. Whether it is of real value as a prophylactic measure at the time of transurethral resection of the prostate has not been statistically evaluated but my results would suggest that it is effective when utilized in this manner.

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Osseous Lesions in the Congenital Rubella Syndrome: A Case Report†

Robert S. Bain, M.D.*
Lexington, Kentucky

The recently described congenital rubella syndrome is discussed. Characteristic osseous lesions and their importance in early recognition of this syndrome are presented.

THE prenatal influence of maternal rubella on the fetus has been well known since 1941 when Gregg[1] reported congenital cataracts in 78 infants following maternal rubella in the early months of pregnancy. It has been reported[2] since then that fetal destruction in utero or a variety of serious congenital defects may occur. The classical features of the rubella syndrome have included deafness, congenital heart defects and cataracts.

Within the past two years, during the rubella epidemic, new aspects of this problem have been recognized. Several observers[3,5] have demonstrated that a fetus infected in utero as a result of maternal rubella during the first trimester of pregnancy may harbor the virus for a variable period after birth. Many organ systems are involved. The virus has been recovered from nasopharyngeal washings, urine, feces, blood and cerebrospinal fluid of affected infants. This presents a hazard to other infants as well as personnel in the nursery. The "expanded rubella syndrome"[4] is now known to include thrombocytopenic purpura, hepatosplenomegaly, a full anterior fontanel, encephalitis, growth retardation and bone lesions. Some infants fail to demonstrate all of these manifestations.

Lesions of the long bones were observed in approximately 60% of the infants with the congenital rubella syndrome in one study[5]. Characteristic osseous changes have become an important factor in early recognition of this entity. The following case represents an instance in which the osseous changes were a major factor in arriving at the correct diagnosis.

Case Report

G. S., a newborn infant, was admitted to the Newborn Nursery of the University of Kentucky Medical Center on January 22, 1964, after an uncomplicated full term assisted breech delivery. Additional history revealed the mother had rubella at approximately two months of gestation. The infant had an Apgar** of 3 immediately following delivery but responded to routine resuscitation measures within approximately 2 minutes. The weight was 2725 grams. The child was rather pale and mildly jaundiced. Contusions and ecchymoses were present over the right lower extremity. Petechiae were noted over both buttocks. There were bilateral cataracts. A grade II pulmonic systolic murmur was present. The liver was palpable three cms. below the right costal margin and the spleen one cm. below the left costal margin. The remainder of the physical examination was within normal limits.

A cardiac consultant diagnosed congestive failure and a large patent ductus arteriosus, which was surgically divided at two weeks of age. There were no post-operative complications.

Extensive laboratory studies were negative except for thrombocytopenia (172,000/cu. mm.) and elevated serum bilirubin (up to 18),

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**Resident in Radiology.*
***Numerical expression of the condition of a newborn infant, at 60 seconds after birth; the sum of points gained on assessment of respiratory effort, heart rate, muscle tone, reflex irritability, and color.*

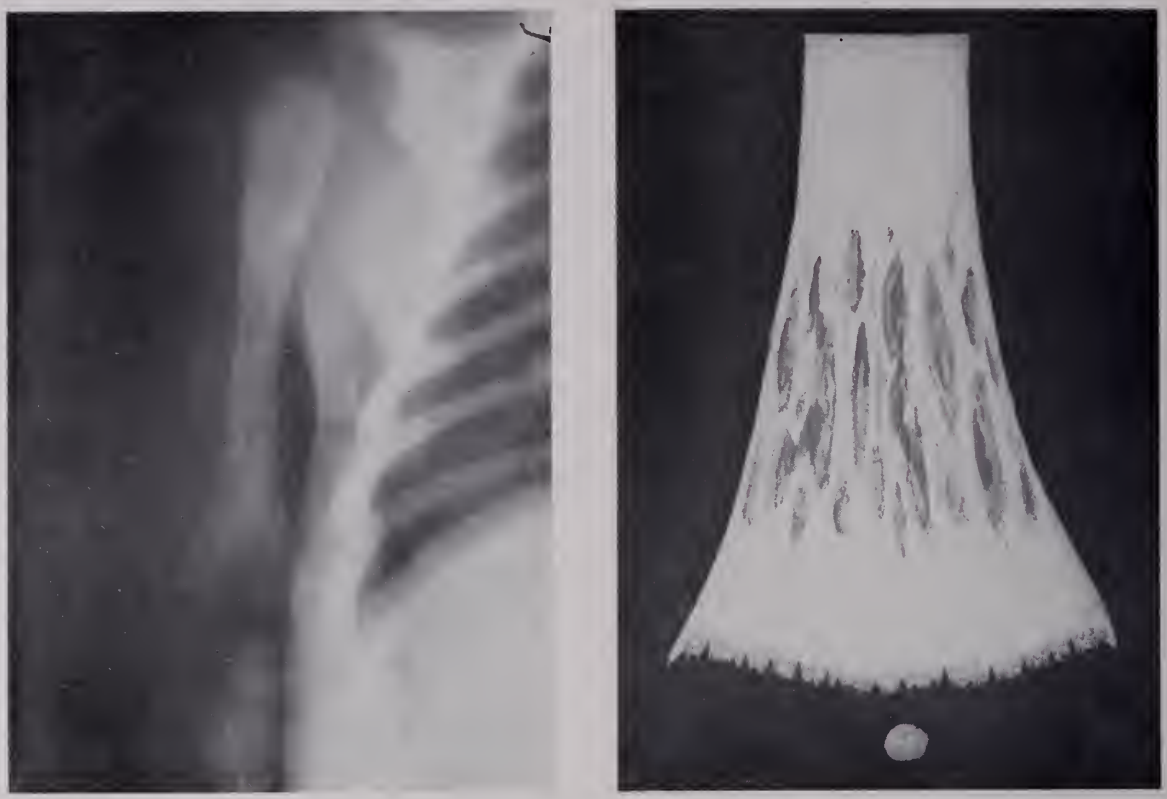


FIGURE 1

(a) Radiograph of humerus showing typical osseous changes.

(b) Drawing of lower femur showing characteristic osseous changes.

both of which eventually returned to normal levels. Radiographs of the long bones of the upper and lower extremities showed linear, somewhat irregular radiolucent defects in the metaphyses of the distal femur and proximal humerus (Figure 1) consistent with the rubella syndrome.

The impression at the time of discharge from the hospital was that this infant demonstrated classical features of the "expanded rubella syndrome" with bilateral cataracts, a patent ductus arteriosus, thrombocytopenia with purpura, hepatosplenomegaly and typical bone abnormalities.

Comment

The characteristic bone lesions of the congenital rubella syndrome are irregularities in the metaphyseal trabecular pattern with small longitudinal or ovoid areas of radiolucency often alternating with longitudinal coarsened, sclerotic trabeculae. These findings may occur in both the upper and lower extremities but are more prominent at the distal end of the femur and proximal end of the tibia. The normally smooth, sharp border of the metaphyseal-epiphyseal junction is poorly defined or interrupted by areas of rarefaction, presenting a frayed or dentate appearance (Figure 1). Although the entire metaphyseal region may occasionally show striking demineralization, the bone trabecular disturbance described above is more diagnostic.

The bone abnormalities are not symptomatic and usually disappear within four to ten weeks without residua except for occasional growth arrest lines. In some affected infants who grow poorly and fail to thrive, bone changes in the form of irregularity of the growth plate and disturbed trabeculae are quite persistent. The zone of provisional calcification may become thick and sclerotic. Occasionally parallel bands of radiolucency and metaphyseal beaking develop.

Absence of involvement of the diaphysis and lack of histological evidence of osseous inflammation indicate these changes are probably secondary to a metabolic or nutritional disturbance rather than to a viral osteomyelitis. The changes are interpreted as representing a

defect in bone formation involving principally the laying down and calcification of osteoid.

In addition to changes in the long bones, an enlarged anterior fontanel is often present. The fontanel extends well forward into the metopic suture in a majority of cases. Suture separation is not consistently present but bulging of the anterior fontanel is commonly observed. One group[6] found that 84% of infants with this syndrome demonstrated the characteristic long bone changes and 56% the enlarged anterior fontanel.

Differential diagnosis includes congenital syphilis and metabolic disturbances such as hypophosphatasia and erythroblastosis fetalis. In congenital syphilis there is usually an associated periosteal reaction which has not been seen in the congenital rubella syndrome. The osseous changes of erythroblastosis fetalis or hypophosphatasia are usually more diffuse, with uniform demineralization. Spontaneous clearing of the radiographic abnormalities excludes such entities as leukemia, neoplasm or pyogenic osteomyelitis.

Summary

A brief review of the characteristic findings in the "expanded congenital rubella syndrome" is presented and a case is reported. The diagnostic features of this syndrome are a history of maternal rubella during the first trimester of pregnancy, congenital cataracts, congenital cardiac anomalies, hepatosplenomegaly, thrombocytopenia purpura, an enlarged anterior fontanel and characteristic changes in the long bones. A brief description of the characteristic osseous lesions is presented.

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SPECIAL ARTICLES

Education for Family Practice, Public Law 89-97, Selective Service Among Items Considered by AMA House of Delegates in Las Vegas*

The editors of The Journal are printing a detailed summary of the actions of the AMA House of Delegates during the 20th Clinical Convention November 27-30 in Las Vegas. Because of its length, it will be carried in installments in this and the February issue of The Journal. The editors feel the actions of the House should have special significance to YOU the individual physician, and urge you to read this report.

EDUCATION for family practice, billing and certification procedures under Public Law 89-97, proposed revisions of the Selective Service System, payments for professional services, compensation for house officers, and use of the terms "ethical" and "unethical" were among the major subjects acted upon by the House of Delegates at the American Medical Association's 20th Clinical Convention held November 27-30 in Las Vegas, Nevada.

Charles L. Hudson, M.D., AMA president, told the Monday opening session of the House that the need to improve existing services and establish new services for the total population should be a "top priority" of the medical profession. He proposed that the AMA and the state and county medical societies launch a continuing program, under predominantly private suspices, for all persons of whatever age, race, creed or color, and he emphasized that it is "among the needy and formerly indigent that I feel we must show interest, initiative and enterprise."

At the Wednesday session Dr. Robert Mayo Tenery of Waxahachie, Texas, general surgeon and past president of the Texas Medical Association, was elected to fill the unexpired term of the late Dr. William A. Hyland, ending June, 1969, on the Council on Constitution and Bylaws.

Final registration reached a grand total of 11,226, which was a record high for an AMA Clinical Convention, and that included 4,574 physicians, which was the third highest physician registration at a Clinical Convention.

Report of F. J. L. Blasingame, M.D., executive vice president, American Medical Association.

Education for Family Practice

Calling it "a document of major importance on a subject of vital significance to the health care of the American public," the House of Delegates endorsed the recommendations of the Ad Hoc Committee on Education for Family Practice and authorized the Council on Medical Education to develop and initiate plans for their implementation. The long report contained the following recommendations:

"A. Major efforts should be instituted promptly to encourage the development of new programs for the education of large numbers of family physicians for the future, as described in the body of this report. The educational programs should relate to all levels of medical education, including pre-medical preparation, medical school education, internship and residency training, and continuing medical education. Keynotes should be excellence comparable to programs in other specialties and flexibility to permit the design of programs which will meet the needs and interests of individual physicians.

"B. Medical schools and teaching hospitals should be urged to explore the possibility of developing models of family practice, in cooperation with the practicing profession.

"C. New sources of financial assistance should be developed for the support of family practice teaching programs. Substantial funds should be made available for all aspects of the programs, including the conduct of the educational program, the recruitment and training of full-time faculty, the development of facilities and models of family practice, and the conduct of research in patient care and community medicine.

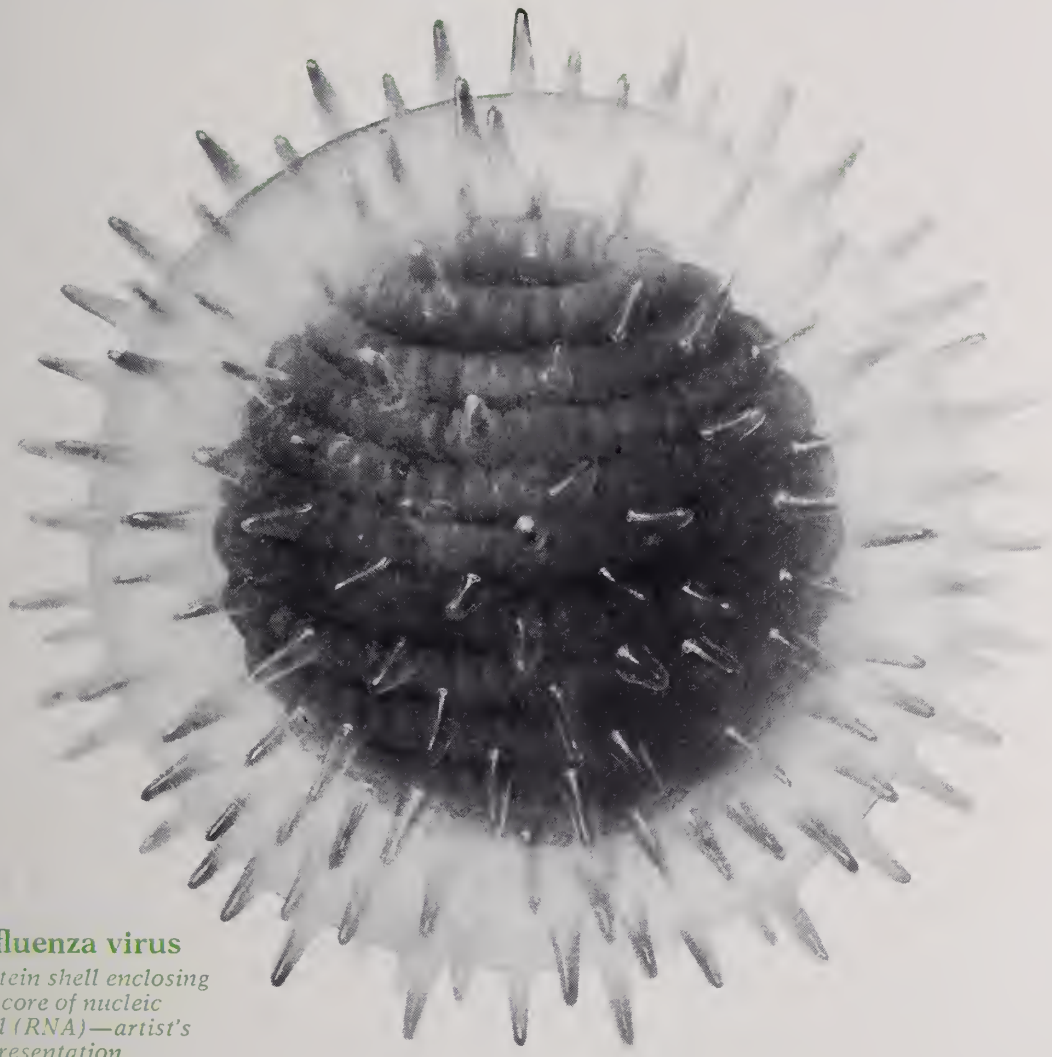
"D. Recognition and status equivalent to other medical specialties should be given to family practice. An appropriate system of speciality certification should be provided for those who have com-

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Influenza virus
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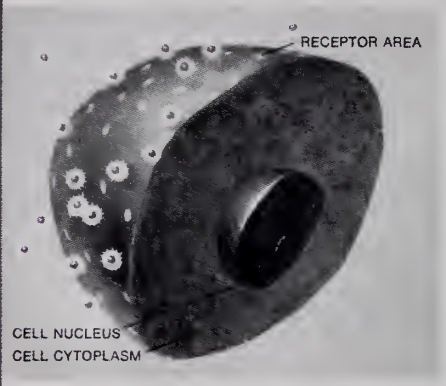
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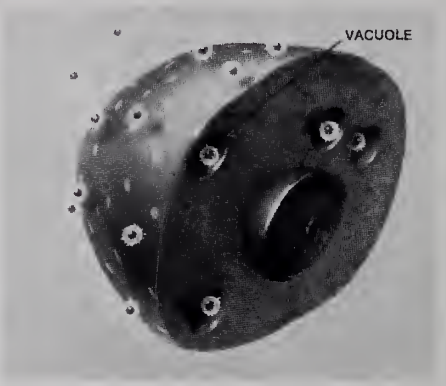
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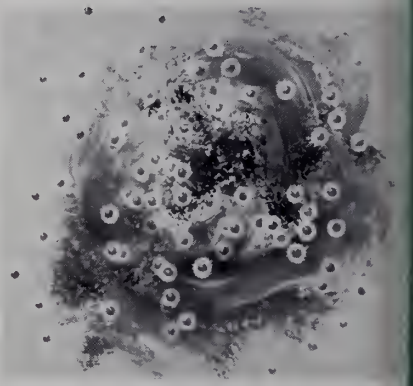
How the influenza virus invades and destroys the untreated cell



1 Viruses outside the cell attach themselves to specific cell receptor areas

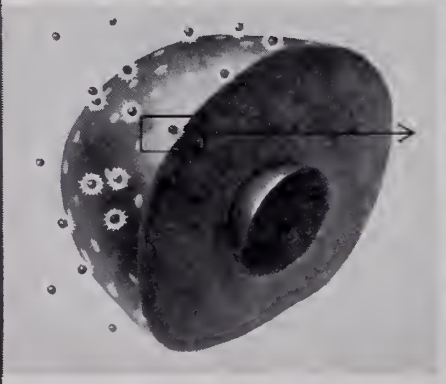


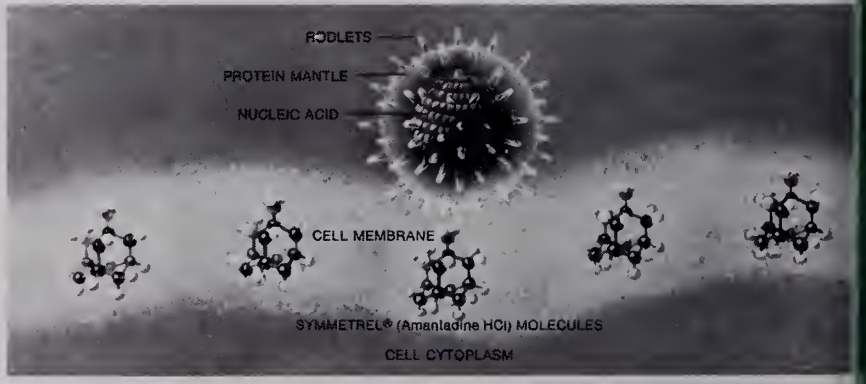
2 The virus is incorporated into a vacuole within the cell. From this vacuole the virus nucleic acid passes into the cell cytoplasm



3 The virus nucleic acid then directs the cell to produce both new virus nucleic acid and virus protein coat material which aggregate to form new virus particles. This process leads to the release of new virus particles and eventual destruction of the cell

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1. "Mode of Action of the Antiviral Activity of Amantadine in Tissue Culture", Hoffmann, C. E.; Neumayer, E. M.; Haff, R. F.; and Goldsby, R. A., Journal of Bacteriology *90*,623 (1965).

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Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures," requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproduction studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully medically while taking "Symmetrel." (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: *Adults:* Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: *Capsules:* Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.
Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.

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Symmetrel®

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A molecular barrier to virus penetration

arrest diarrhea

in • gastroenteritis • acute infections



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride . . . . . 2.5 mg.

(Warning: May be habit forming)

atropine sulfate . . . . . 0.025 mg.

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.



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ctive in a wide range of everyday infections — respira-, urinary tract and others — in the young and aged — acutely or chronically ill — when the offending organ-s are tetracycline-sensitive.

traindication — History of hypersensitivity to demethyl-rtetracycline.

rning — In renal impairment, usual doses may lead to essive systemic accumulation and liver toxicity. Under h conditions, lower than usual doses are indicated , if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or ficial sunlight has been observed. Small amounts of g and short exposure may produce an exaggerated burn reaction which may range from erythema to ere skin manifestations. In a smaller proportion, pho-llergic reactions have been reported. Patients should id direct exposure to sunlight and discontinue drug at first evidence of skin discomfort.

cautions and Side Effects — Overgrowth of nonsuscep-e organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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■ quickly relieves congested nose
■ action is gentle, yet prolonged
■ side effects are minimal

INDICATION: Nasal congestion. CONTRAINDICATION: Do not use in patients sensitive to small doses of sympathomimetic substances. WARNINGS: Prolonged or excessive use may cause rebound congestion. Use cautiously in patients with hyperthyroidism, coronary artery disease, hypertension, and diabetes. CAUTION: Do not shake Nasal Spray. Rinse Nasal Solution dropper or Nasal Spray tip in hot water after each use. No more than one person should use the same dropper bottle or nasal spray.
SIDE EFFECTS: Occasional local reactions: rebound congestion, slight burning or stinging, sneezing, dry nose. Occasional systemic effects: headache, drowsiness, lightheadedness, insomnia, palpitations. Overdosage in young children may produce profound sedation. DOSAGE: **Adults:** *Nasal Solution*—2 or 3 drops in each nostril every 4 to 6 hours. *Nasal Spray*—Squeeze rapidly once or twice in each nostril every 4 to 6 hours. **Children under 12:** *Pediatric Nasal Solution*—2 or 3 drops in each nostril every 4 to 6 hours. One drop should be used in infants under 6 months. *Pediatric Nasal Spray*—Squeeze rapidl once in each nostril holding tube upright; repeat every 4 hours a necessary. SUPPLIED: OTRIVIN® hydrochloride (xylometazoline hydrc chloride CIBA) *Nasal Solution*, 0.1%; dropper bottles of 1 fluidounce bottles of 1 pint. *Nasal Spray*, 0.1%; plastic squeeze tubes of 15 m *Pediatric Nasal Solution*, 0.05%; dropper bottles of 1 fluidounce. *Ped atric Nasal Spray*, 0.05%; plastic squeeze tubes of 15 ml. *Nasal Solu tions* contain either 0.1% or 0.05% xylometazoline hydrochloride triethanolamine, hydrochloric acid, sodium chloride, and phenylme curic acetate 1:50,000 as preservative in water. *Nasal Sprays* contai either 0.1% or 0.05% xylometazoline hydrochloride, potassium phos phate monobasic, potassium chloride, sodium phosphate dibasic sodium chloride, and benzalkonium chloride 1:5000 as preservative i water. *Consult complete literature before prescribing.*
CIBA Pharmaceutical Company, Summit, N. J.

C I B A

2/3329 MKL•1

pleted approved educational programs and have demonstrated their competence as family physicians. The graduate program (i.e., internship-residency program) should be an integrated whole, evaluated for accreditation by one body rather than two.

Payments for Professional Services

To clarify AMA policies as they now exist, the House adopted the following eight-point statement regarding payment for professional medical services:

"1. It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.

"2. It is proper for third party agencies to make payment of professional medical fees in behalf of patients, with recognition of the fact that the service of the physician has been to the patient and the liability for payment rests primarily with the patient or his family.

"3. It is proper for a physician to work cooperatively with other physicians in a team approach to the provision of medical service, with recognition of the fact that each cooperating physician is entitled to compensation according to the value of his services, and that the charges attributable to each physician's service shall be made clearly known to the patient.

"4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.

"5. A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the Principles of Medical Ethics and established policy of the American Medical Association.

"6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit and disburse as they may agree.

"7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.

"8. The physician is the sole arbiter as to the ways in which he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association."

Compensation for House Officers

The House approved the first four sections of a joint report by the Council on Medical Education and Council on Medical Service. Those sections provided new guidelines on the utilization of private patients in teaching programs; recommended principles to govern the assignment of professional responsibility of house officers for the care of paying patients; presented interpretations of the 1961 statements by the House concerning remuneration of house officers and the increasing responsibility of the medical profession for the development of appropriate methods of financial support for interns and residents, and recommended a statement to guide medical staffs in the development of additional funds to supplement, if necessary, those from hospital sources.

The House then modified or added the final four sections as follows:

E. The presently published provisions for payment under Part A, Title 18, Public Law 89-97 for services rendered to beneficiaries by interns and residents, and under Part B, Title 18, Public Law 89-97 for services rendered by attending physicians supervising interns and residents, are compatible with the organization and administration of programs of graduate medical education according to the standards of the American Medical Association. The principles embodied in these provisions should uniformly apply to regulations governing all other third party medical care plans.

F. It is recommended that sources and amount of compensation for house officers should be determined by local agreement and implemented in accordance with state laws and the ethical principles and policy positions of the American Medical Association.

G. The above principles should be widely publicized so that they may be understood and implemented in good faith by all concerned.

H. The broad and complex nature of the problems in the financial area is recognized, and continued studies and reports thereon by the Council on Medical Service are encouraged. These should include staff compensation, methods of fund collection, control and disposition, and other pertinent and related matters.

Use of the Terms "Ethical" and "Unethical"

The Judicial Council, which had been asked to comment on use of the terms "ethical" and "unethical," submitted the following report which was adopted by the House:

"Historically, the term 'ethical' has been used in opinions and reports of the Judicial Council and in resolutions adopted by the House of Delegates to refer to matters involving (1) moral principles or practices; (2) customs and usages of the medical profession; and (3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term 'unethical' has been used to refer to conduct which fails to conform to these professional standards, customs and usages, or policies, as interpreted by the American Medical Association.

"Unethical conduct involving *moral principles*, values and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

"Failure to conform to the *customs and usages* of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in

question may reflect upon the dignity of and respect for the medical profession.

"In matters strictly of a policy nature, a physician who disagrees with the position of the American Medical Association is entitled to freedom and protection in his point of view."

Other Actions

In considering 63 resolutions, 22 Board reports and a wide variety of additional reports and materials from councils and committees, the House of Delegates also:

Approved establishment of a new *Committee on Continuing Medical Education* but also urged that lines of authority be clearly defined by the Board of Trustees in consultation with the Council on Medical Education in order to avoid duplication of responsibilities already assigned to the Council;

Instructed AMA members of the Joint Commission on Accreditation of Hospitals to express grave concern regarding the accreditation of hospitals in which *laboratories* are directed by non-physicians or physicians not adequately qualified in laboratory medicine.

Passed two resolutions opposing the *"dual fee"* practice of determining the rate of payment for a physician's services solely on the basis of his type of practice;

Approved a Board report recommending that *Social Security* laws be amended so that physicians entering the program for the first time may obtain earlier eligibility and improved benefits;

Recognized the increasing importance of *medical society review committees,* reaffirmed the guidelines published in the November 29, 1965, issue of JAMA and endorsed additional principles recommended by the Council on Medical Service;

Urging continuing, vigorous effort to dissuade local officials from demanding that physicians sign civil rights *compliance statements* that are not required by law or by federal directives;

Recommended that state medical societies seek the passage of state legislation which would provide a physician who serves on a *utilization review committee immunity* from litigation arising from the activities of such committees;

Asked that the Board of Trustees direct the Council on Legislative Activities to continue to pursue with committees of Congress the need for amending the *Self-Employed Individuals Tax Act* to provide self-employed individuals with opportunities for deferring current earnings and taxes comparable to opportunities presently enjoyed by employed individuals;

Requested the Bureau of the Budget to modify the cost accounting system of *Veterans' Hospitals* to permit comparison with cost accounting in community hospitals to the end that economy, efficiency and patient care can be properly assessed in Veterans' Hospitals;

Reaffirmed its support of the principle that every ethical licensed doctor of medicine who needs and desires them should have *staff privileges,* commensurate with his training and skill, in at least one accredited community hospital;

Recommended that each *hospital* should have at least one voting doctor of medicine member on its *Governing Board* who, preferably, should either be appointed or elected by the hospital medical staff from its membership;

Pointed out that there is a definite need for utilization committees and declared that *tax supported hospitals* and private hospitals should be governed by the same utilization standards;

Approved Board recommendations that "the AMA support the need for a significant improvement in the income of the *registered nurse*" and that "the AMA continue to support in principle all current nationally approved educational programs for nurses";

Agreed with the Board that the Council on Postgraduate Programs be renamed as the *Council on Scientific Assembly* and that its functions be redefined to enable concentration on AMA scientific meetings;

Adopted a resolution that the AMA take measures to insure the attention of medical societies to the need for appropriate utilization of *retired physicians and inactive nurses*;

Passed a resolution on the determination of *elderly applicants'* eligibility for automobile liability insurance and driver licensure which said that "although physicians are willing to examine applicants and determine whether or not the applicant meets specified physical standards for automobile liability insurance or for licenses to operate motor vehicles, the determination of what standards should be required or whether the driver is insurable and should be licensed to drive is the responsibility of the insurance companies concerned and of the state agencies issuing licenses, respectively";

Rescinded Resolution 104 which had been adopted by the House in June, 1966;

Endorsed the principle of *free choice* of physician and medical facility under Title XIX of Public Law 89-97;

Urged that the AMA continue to promote constructive legislation improving *existing governmental health plans* and continue to offer constructive advice;

Authorized the Board of Trustees to continue the *AMA Members Disability Program* beyond August 31, 1967; make every effort to continue the program with the same premium-benefit structure; clarify the existing program, and, if necessary, renegotiate a revised program which will be financially sound and will provide the best possible benefits and protection for present and future participants;

Approved a Board recommendation that no special section of *The AMA NEWS* be set aside for county society communications, but that news of county society activities continue to be an important part of *The AMA NEWS*;

Agreed with the Board that, effective January 1, 1967, the AMA should discontinue paying for the rental of the *TWX equipment* in state medical society offices,

(Continued next month)

EDITORIALS

— — A Fable For Our Times — —

Jethro

ONCE upon a time there was a fat cat named Jethro. Jethro was fat, and he was also built mighty big — say about four feet high at the shoulder. He lived in this jungle, see, and he noticed that when he roared, everybody ran — away, that is. He grew up in a family of big striped cats, and they all had a real fine childhood. Nobody, absolutely nobody, bothered him or his family, and those cats got a pretty grand notion of their own importance — not overinflated, you understand, just realistic. They were natural-born leaders.

When everybody was full grown they agreed to split up, and live in different parts of the jungle. They had to — no one place could support that much talent. Jethro was a staunch individualist, and so things got even better then, when he got out on his own. He formed what you might call a great and good friendship with a swinging kitty called Esmerelda, and together they made the scene. Life was (except in July and large parts of August) cool, man.

As time went by, though, certain of the smaller citizens in the jungle violated a natural law — they became not only older, but smarter. The cats unique approach to mortality statistics had begun to make things tough in the local economy, and the citizens asked all the cats to dine more on members that could be pre-planned for such a purpose — mothers-in-law, idiot cousins, and the like — and leave Pop and Mom alone so they could get on with the business of procreation. The cats didn't like to be told what to do, especially by people who knew nothing of the cat business, and they growled and grumbled and started to say no. So the citizens, just to heat up the cats' thought processes a bit, set up a cleverly designed fire upwind, and it was only by hanging on to each others' tails that the cats escaped to the river through the smoke. As they sat in the hot water the cats pointed out to the citizens that the old jungle would never be the same. They also, however, recognized that cats who've got responsible positions have responsibilties, too, and they began to work together towards some economic alternatives to the old status quo.

Everybody seemed to agree about this but Jethro. Jethro, our individualistic friend, whose dislike for outside instructions was exceeded only to his loathing for organizations of all sorts, had of course not hung on to anyone, and had perished in the fire.

MORAL: Sometimes having a tiger by the tail, in a group, beats getting too hot under the collar, independently —Pay your KMA and AMA dues!

WALTER I. HUME, M.D.

The Use Of Diagnostic Isotopes In The Community Hospital *

THE field of Nuclear Medicine is no longer the toy of research scientists in the "ivory towers of learning." It has developed into a very useful, and occasionally essential, adjunct in the present day practice of medicine. A good radioisotope facility should be considered as indispensible to the practice of good medicine as are general laboratory and x-ray facilities.

Since radioisotopes became commercially available in 1945, there has been a rapidly expanding clinical application throughout the United States. With the increasing range of applicability being made available in all size medical units, the number of diagnostic radioisotope procedures performed yearly continues to grow at a very rapid rate. The exact number of procedures that are being done per year is not known, but this information will be forthcoming from a nationwide survey authorized by the United States Public Health Service.

There are numerous items of diagnostic information that can only be attained by radioisotope techniques, and a much larger list of data that can be attained easier and with more precision with radioisotope techniques. The role of diagnostic radioisotopes in the present day practice of medicine is attested to by the frequency with which they are mentioned in all medical literature. The number of articles is so voluminous and widespread that abstract services devoted to Nuclear Medicine have been initiated, and selected articles in the diagnostic uses appear in the Year Book of Nuclear Medicine.[1]

The variety of diagnostic radiosotope procedures that are being routinely utilized in medical centers is also constantly expanding. This growth is due to the increasing use of newer isotope compounds and better equipment development. From the original applications of $Na^{130}I$, $Na^{131}I$, and $Ha_2H^{32}PO_4$ in 1945, there has been a constant expansion to the present. A recent compilation by Silver[2] lists 38 radioisotopes in 80 compounds presently being used in diagnostic applications, and the numbers are still increasing. About one-half of those listed might be considered applicable for "standard" diagnostic procedures in a large radioisotope facility.

Many smaller hospital units have not yet instituted programs providing diagnostic isotope service. As these smaller units become staffed by physicians who have been trained to utilize the type of information that can be ideally or solely attained by radioisotope techniques, the desire or demands for such a service will increase.

There is a number of factors to be considered by a hospital desirous of initiating a radioisotope service. These factors are not particularly troublesome or difficult to solve, but must be considered in planning for such a service. Most of these same factors are present in the stipulated requirements for licensure to use radioactive materials set forth by the Kentucky State Department of Health in Radiological Health "RH" Regulations: Pam. RH-2 (10-64) for human use in institutions.

The first and foremost requirement is in having at least one physician who is sufficiently interested in supervising this service to become adequately trained and licensed. This same individual would logically have responsibility for the service, and hopefully would have the enthusiasm to promote the use of radioisotope techniques. The basic licensure requirements for training are set at a minimal level for the standard diagnostic applications, and would not require an extended period of training at one of the many available post-graduate training centers. Training courses that will meet the minimum requirements can be completed in as short a time as one week. More extensive training programs are now available that offer up to one year of full time training. Preliminary training in a medical specialty is not a prerequisite. Radiology is the only specialty that requires training in Nuclear Medicine.

A technician trained to carry out the technical aspects of the procedures is also essential.

*Section of Nuclear Medicine, Department of Radiology, University of Kentucky Medical Center, Lexington

The technical aspects may be performed by the trained physician at the onset, but the time involved will soon be an excessive use of physician time. Technicians from other disciplines can be trained to do the radioisotope procedures, and some experience in radioisotope techniques is now offered in most schools for laboratory and x-ray technicians. There are a few training courses planned specifically to train technicians in Nuclear Medicine.

The space requirements are relatively minimal in a basic unit. With a service providing a limited range of diagnostic procedures, the space requirement may not exceed a portion of the general laboratory space or diagnostic x-ray space. This space must be accessible both to in-patient and out-patient traffic. As the volume of activity increases, and as more extensive instrumentation is required, the space needs will increase. The space demands could develop into a requirement for a separate suite of rooms to adequately accommodate the service demands.

The electronic and laboratory equipment needed for a diagnostic radioisotope service will be dictated by the range and volume of services to be provided. Some components of various systems can be inter-connected to extend the range of procedures that are to be offered. A moderate number of the standard laboratory type isotope procedures can be performed with minimal equipment. The technically more-complicated procedures, such as mechanical scintiscanning and scintiphotography, require considerable more electronic sophistication and space.

It is obvious from my comments that I feel that diagnostic radioisotope service should be available in all modern hospital facilities. The range of services provided will be dictated by the patient population, interest of the staff physicians, and availability of trained personnel. The time has come and gone when such services should be considered applicable only to large teaching centers, and now belong in the armamentarium of every well equipped hospital.

References

1. Year Book of Nuclear Medicine, James L. Quinn, III, M.D., et. al. Year Book Medical Publishers, Inc., Chicago, 1966.
2. Silver, S., Uses of Radioisotopes in Medicine, *Nucleonics* 23, pp. 106-111, Aug. 1965.

KENNETH R. MCCORMACK, M.D.

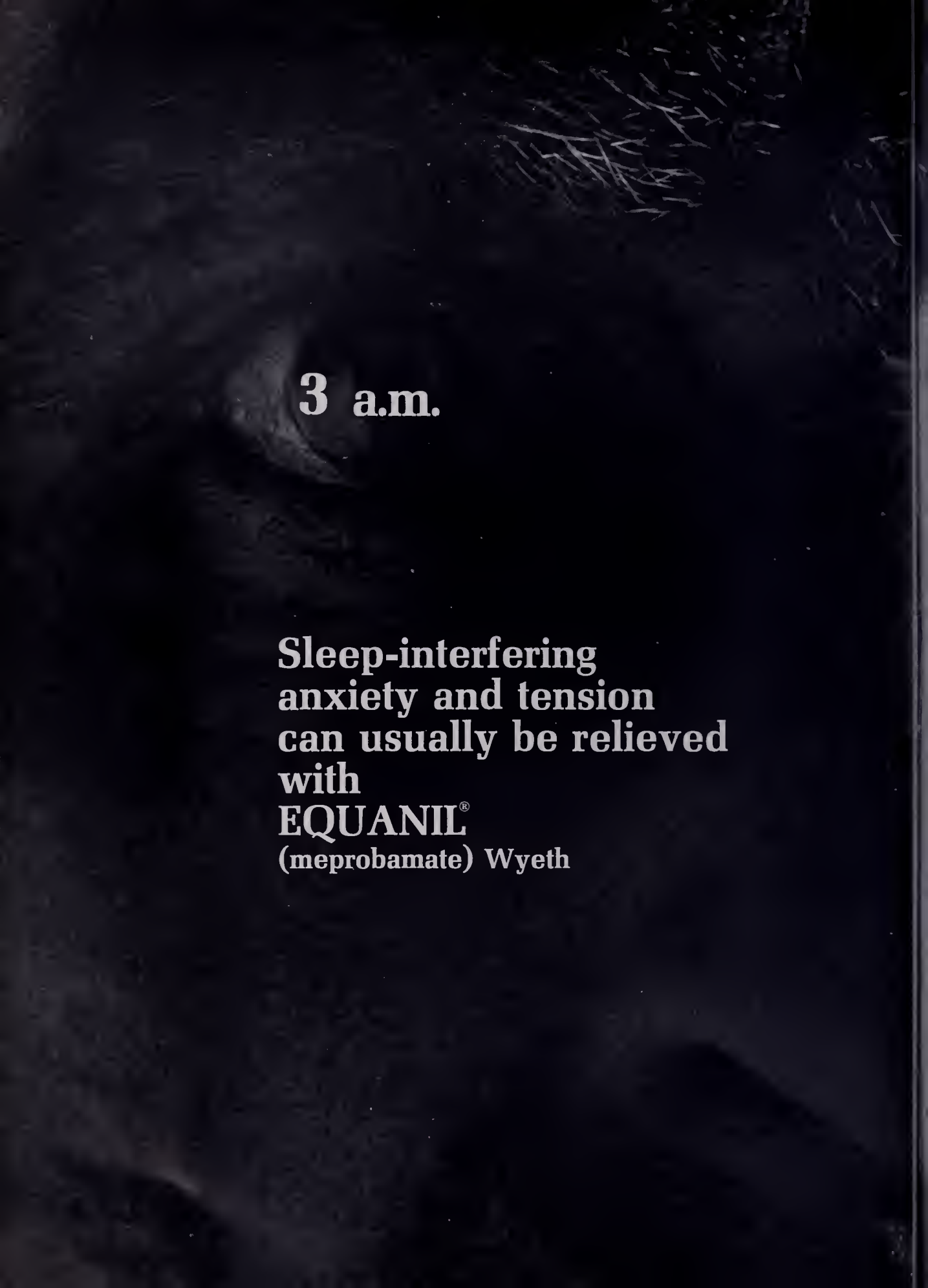
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April 19-20

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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ORGANIZATION SECTION

Dr. Blasingame Slated to Speak At 1967 Interim Meeting

F. J. L. Blasingame, executive vice president of the AMA, will be one of five outstanding guest speakers at the 1967 KMA Interim Meeting at Ken-Bar Inn, Gilbertsville, on April 19 and 20, according to an announcement from Robert E. Pennington, M.D., KMA president.



Dr. Blasingame

Doctor Blasingame will speak on "A Profession United" at the luncheon session which will close the meeting on Thursday, April 20. A speaker of national stature is scheduled to speak at the dinner which will open the meeting on the evening of the 19th, Doctor Pennington said.

Theme of the two day conference will be building a strong, united profession. The Thursday morning session will include three presentations. Subjects to be discussed will be voluntary health coverage, political action—"Working to Win", and "Health Manpower".

Known to his friends as Bing, Doctor Blasingame is a native of Arkansas. He received his M.D. degree from the University of Texas in 1932. He was president of the Texas Medical Association in 1955 and was a member of the AMA Board of Trustees from 1949 to 1958. Doctor Blasingame was elected to his present position in 1958 and in 1962 was reappointed for another five year term in that office.

All KMA members are urged to attend the Interim Meeting which Doctor Pennington says he expects will be one of the "best yet". More details on the meeting will be carried in subsequent issues of the Journal.

KMA Third, First and Second Dist. To Meet Jan. 24, 25, 26

Three KMA Trustee District meetings have been scheduled by their respective trustees for later this month. Wives of the members of these districts are invited to attend.

Robert E. Pennington, M.D., London, KMA president, will be a featured speaker at all three of these meetings.

Robert C. Long, M.D., Louisville, will speak briefly at the Third and First Trustee District meetings in behalf of KEMPAC. A KEMPAC speaker for the Second District meeting has not been announced.

Mrs. Raymond E. Jones, Louisville, president of the Woman's Auxiliary, has reported that the auxiliaries in these districts will hold separate meetings simultaneously with the individual district, after being together during the dinner sessions.

The Third Trustee District, Gabe A. Payne, Jr., M.D., Hopkinsville, trustee, will meet at the Hopkinsville Country Club Tuesday evening, January 24.

First District, Joseph R. Miller, M.D., Benton, trustee, will meet at the Paducah Country Club Wednesday evening, January 25.

The Second District, of which Gerald Edds, M.D., Calhoun, is trustee, will hold its meetings at Gabe's Restaurant in Owensboro on Thursday, January 26.

Each trustee has indicated that all members in his district have received personal invitations.

Eight KMA Members Named to AMA Councils and Committees

Donn L. Smith, M.D., dean of the University of Louisville School of Medicine, has recently been named to the important AMA Council on Drugs. His appointment was announced by F. J. L. Blasingame, M.D., AMA's executive vice president.

The appointment of other KMA members to serve on AMA committees by the AMA Board of Trustees has also been announced.

Reappointed to the Committee on Medical Aspects of Automotive Safety is William K. Keller, M.D., Louisville. Doctor Keller is nationally recognized in this field.

Also reappointed is William T. Rumage, Jr., M.D., Louisville, to the Committee on Disaster Medical Care.

Frederick R. Scroggin, M.D., Dry Ridge, has been reappointed to serve another year of the AMA's Committee on Quackery.

Robert Lich, Jr., M.D., Louisville, has been named to serve another year on the Sub Committee on Reproductive and Urinary Systems.

William R. Willard, M.D., vice president of the University of Kentucky Medical Center, who serves on the AMA Council on Medical Education, has been reappointed as a member of the Commission on Research; and Nicholas J. Pisacano, M.D., also of the University of Kentucky, is a member of the Committee on Rehabilitation.

Carroll L. Witten, M.D., Louisville, who is serving as president of the American Academy of General Practice, has been appointed as an alternate member for the AAGP of the Interspecialty Committee.

These appointments were made by the AMA Board of Trustees, of which Robert C. Long, M.D., is a member.



Dr. Rob



Dr. Hollifield

12th Lexington Clinic Conference Set for March 30

"Medical and Surgical Problems in the Aged" is the theme of the Lexington Clinic's 12th Annual Spring Conference in Lexington on March 30. Two well-known speakers from out-of-state will headline the program.

Guy F. Hollifield, M.D., professor of medicine, Northwestern Medical School, Chicago, will speak on "A More Hopeful View of Atherosclerosis" at 11:30 a.m. Charles Rob, M.D., chairman and professor, department of surgery, University of Rochester, Rochester, N.Y., will talk at 2 p.m. His topic will be, "Arteriosclerosis—Surgical Concepts".

"Emotional problems of the Aging" will be explored by luncheon speaker Irving Gail, M.D., Lexington psychiatrist.

Morning Program

Registration, with coffee, will begin at 8:30 a.m. EST, followed by a welcome from Allen Cornish, M.D., Lexington. Other subjects and speakers include: "Cranial Arteritis", Leslie W. Blakey, M.D.; "Emphysema in the Elderly", Kenneth C. Tufts, M.D.; "The Gastrointestinal Tract in the Aged", David H. Johnston, M.D.; "Rheumatoid Arthritis in the Aged", C. Richard Gill, M.D.

Following intermission talks will include: "Recent Advances in the Care of Myocardial Infarction", M. Cary Glaydes, M.D.; "The Aging Skin", James W. Bard, M.D. Following a question period Doctor Hollifield will speak. All speakers are from Lexington unless otherwise specified.

Afternoon Session

Richard D. Floyd, M.D., will moderate the afternoon program which will begin with Doctor Rob's presentation. Other topics will include: "Morbidity and Mortality of Major Surgery in the Aged", Eugene Todd, Jr., M.D.; "Hysterectomy in the Post-Menopausal Woman", Carl T. Evans, M.D.; "The Elderly Eye", James L. Stambaugh, M.D., and "The Great Imitator", John R. Cole, M.D.

State Board of Health Seeks KMA Aid in Finding M.D. Replacements

The State Department of Health is looking for qualified physicians to fill at least five vacancies at the state level.

The KMA Board of Trustees has received a request from the State Board of Health seeking the KMA Board's assistance in finding the much needed replacements. The Board of Health made the request at its November 17 meeting, according to Russell E. Teague, M.D., secretary, Frankfort, who transmitted the request.

"There is a real opportunity for career development for young physicians who wish to specialize in that field of public health," Doctor Teague said. He indicated that there are many vacancies in the county offices in addition to those in the state office.

"The Board of Trustees of KMA is most sympathetic to this man-power problem and will be glad to assist the Department in anyway it can", Rex E. Hayes, M.D., Glasgow, chairman, stated.

Physicians wishing to investigate these openings should either contact Doctor Teague at the State Department of Health in Frankfort or the KMA Headquarters Office.

KMA Continues Participation In Cornell Auto Injury Study

KMA is participating in a new three-year Automotive Crash Injury Research Program (ACIR) coordinated by Cornell Aeronautical Laboratory, Inc. which began January 1, 1967. The first such three-year project conducted in Kentucky was successfully completed in July, 1965.

Sponsored by KMA, The Kentucky Department of Health, The Kentucky Hospital Association, and The Kentucky State Police, the purpose of this program is to obtain reliable data on the frequency, nature, and specific causes of injury to occupants of recent model passenger cars involved in rural accidents.

The first six-month phase of the new program will be held in the counties of Anderson, Boyle, Clark, Estill, Fayette, Franklin, Garrad, Jackson, Jessamine, Lee, Lincoln, Madison, Mercer, Owsley, Scott, Shelby, Spencer, and Woodford. If you are a physician in one of these counties, you may be asked to participate in this data-collecting project.

Whenever an occupant of a passenger car of the last five year model is injured or killed in an accident, the investigating state police officer will bring to the hospital or private physician treating the victim, a special medical report form provided by Cornell inscribed with the patient's name, the date, time, and location of the accident, and the seated position of the injured occupant.

You will be requested to complete the form by recording specific information on the extent and nature of all injuries, no matter how minor. These forms are brief and require little time. Sampling areas are rotated every "six months" so that you will experience a minimum of extra work in connection with this study.

William K. Keller, M.D., Louisville, KMA Highway Safety Committee Chairman, urges your cooperation in this effort to reduce deaths and injury in future automobile accidents.



William K. Keller, M.D., Louisville, right, Chairman of the KMA Highway Safety Committee, presents KMA's Automotive Safety Award to Colonel James E. Bassett, left, Director of the Kentucky State Police, at KMA Headquarters.

KMA Auto Safety Award Presented To State Police Head

KMA's Automotive Safety Award was presented to Colonel James E. Bassett, Director of the Kentucky State Police, on November 30, at the Highway Safety Committee Meeting at KMA Headquarters.

The Award was presented by William K. Keller, M.D., Louisville, chairman of the committee. The Award was given in recognition of a State Police rule requiring all troopers to wear seat belts while driving.

Doctor Keller said, "The KMA Award is given to any group or organization which gets 100 per cent of its members to have seat belts installed in every car operated by the membership."

The objective of the Highway Safety Committee, according to Doctor Keller, is " . . . to decrease deaths and disabilities caused by motor vehicles".

Former Kentucky Governor Elected To Head Appalachian Hospitals

Bert T. Combs, former governor of Kentucky, was elected chairman of the Board of Trustees of the Appalachian Regional Hospitals on December 8 in Lexington. He succeeds Garvice D. Kincaid, Lexington, who will continue on the ARH Board.

The thirty members of the Board of Trustees of the Appalachian Regional Hospitals, including the chairman and vice-chairman, serve without pay.

T. P. Hipkens, a Pittsburg, Pa., hospital administrator, became president of ARH on January 1. Six of the system's hospitals are in Kentucky; Harlan, Hazard, McDowell, Middlesboro, South Williamson and Whitesburg. The others are at Beckley and Man, W. Va., and Wise, Va.

Medicare Experience Described By Insurance Carrier*

Government-sponsored health insurance for citizens over 65 years of age has been in effect for slightly more than five months. Metropolitan Life Insurance Company has served as the carrier for the supplementary insurance program (Part B) which provides payment for physicians' services in the Commonwealth of Kentucky. Through November, 1966, the Company's Medicare office in Lexington processed approximately 28.200 bills under this program. Of the total bills processed, over 15,000 were applied toward the $50 deductible credit and hence did not permit payment. However, more than 13.000 bills were paid for a total cash amount in excess of $860,000. About 55 percent of the bills were from physicians who had accepted the "assignment" method of payment, but it must be realized that approximately 30 percent of the paid claims involved welfare recipients.

Supplementary insurance, or Part B, payments are made on the reasonable charge basis. This means that the actual charge on a bill will be honored as long as it is within the individual physician's customary fee range and does not exceed the prevailing fee of other physicians with the same qualifications for the same procedure within the locality. Because Metropolitan Life Insurance Company has had long experience in Kentucky with Major Medical and with other health insurance plans carrying no set fee schedule, it was possible to supply the Company's Lexington Medicare office with prevailing fee information with variables for geographic location and physicians' qualifications.

Only a small percent of the bills processed to date required special attention because of fees that were questionably high. Many of these cases con-

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**Prepared by Claude M. Eberhart, M.D., M.S.P.H., coordinator of medical relations, and Donald R. Smith, manager, Medical Insurance Benefits, Social Security Act, Metropolitan Life Insurance Company.*

***A list of references used in preparation of this article is on file in the KMA Headquarters Office.*

tained inadequate information on dates, types of service and diagnosis. Most of these were adjusted satisfactorily by telephone discussion with the physicians involved or his Medical Assistant. The more difficult cases were referred to the Home Office where they were studied by officers of the Medical Department and Group Claims Division. On the basis of this experience, our screening mechanisms were changed to cover unforeseen situations. It is noteworthy that there has been no instance in which the "reasonable" fee as decided by the Company has been challenged as unfair and a hearing or informal review requested.

In the organization of the Lexington Medicare office, Metropolitan engaged the services of Francis M. Massie, M.D., of Lexington with whom Mr. Smith (co-author of this article and Manager of the Lexington office) consults concerning questions of service rendered and charges made. Physicians should not be surprised to receive a telephone call or other communication from Doctor Massie who may often need more information in order to advise the claim adjudicators. Doctor Massie may arrange meetings with the county medical societies from time to time to discuss problems which may arise.

The smoothness of this early Medicare operation has been in no small part due to the cooperation of the medical profession. As the program becomes fully effective and interim requirements are replaced by statutory or regulatory demands, the cooperation of the practicing physicians will be even more important. Information concerning the full program has been widely disseminated and potential problems for the medical profession have been identified. Review of these will indicate areas that should receive further consideration and action. Some of these are identified in the following discussion.

Beneficiaries and physicians, as assignees of beneficiaries, are afforded review mechanisms through the carrier if they feel their claims have been unfairly settled. In addition, the A.M.A. House of Delegates in October, 1965, adopted a statement to the effect that disputes between physicians and carriers with respect to fees should be resolved in participation with the local medical society. One means of handling such disagreements is by the formation of a medical society review committee. Guidelines for the establishment of review committees have been published and the philosophy of their operation has been described.

Since the law requires that physicians' services rendered to a patient be paid out of premiums collected for supplementary insurance as opposed to hospital benefits paid from social security tax funds, it is necessary that hospitals and hospital-based physicians (excepting interns and residents in an A.M.A.-approved training program) determine and conclude agreements as to the proportion of the physician's service devoted to patients—as opposed to administration, teaching, research and other duties rendered the hospital. The proportion of the physician's service to patients for supplementary medical insurance beneficiaries is then estimated and related to his total compensation. The methodology is described in the Federal Register and requires maintenance of records to substantiate the agreements.[8] The resulting schedule of charges to be deemed reasonable should then yield the physician in the *aggregate* an amount equal to such portion of his total compensation. The required records will be reviewed periodically by the fiscal intermediary and carrier to assure that the pro-rated charges are reasonable.

Although bills for diagnostic services performed by independent laboratories are accepted without question, it is only a matter of time until bills can only be honored from independent laboratories licensed or approved by the Commonwealth of Kentucky.

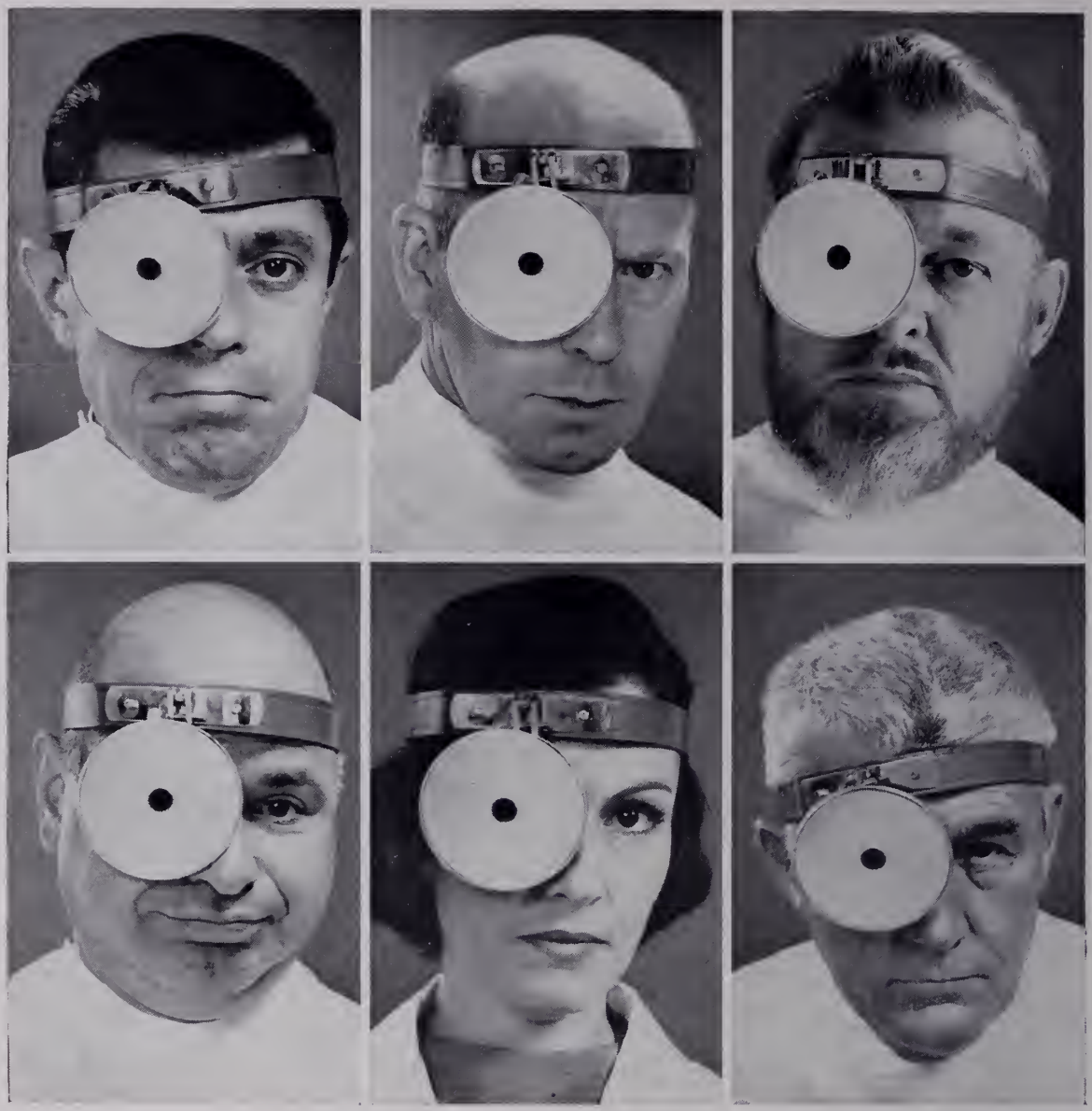
By maintaining two-way communication between the medical profession and the Company's Medicare office, misunderstandings can be avoided and harmonious working relationships established. Questions, comments and discussions with physicians are welcomed and encouraged by Metropolitan Life Insurance Company at all times.

Ky. Doctors Attend AMA Meeting in Las Vegas in Nov.

Forty-five KMA members attended AMA's 20th. Clinical Convention at Las Vegas, November 28-30.

According to the records from the AMA, the following Kentucky physicians attended:

John Ammon, Hebron
George P. Archer, Prestonsburg
W. H. Armbruster, Louisville
Thomas H. Biggs, London
Charles G. Bryant, Louisville
Neal Calhoun, Madisonville
Robert G. Callaway, Valley Station
James C. Cantrill, Georgetown
E. S. Carter, Jr., Hazard
Robert Cofield, Covington
David M. Cox, Louisville
M. R. Cronen, Louisville
B. Cymbala, Henderson
Royce E. Dawson, Owensboro
James D. Faulkner, Fort Thomas
Hoyt D. Gardner, Louisville
Frank B. Gross, Harlan
William W. Hall, Owensboro
James A. Holbrook, Prestonsburg
Donald G. Hughes, Murray
Ann Hardie Johnson, Owensboro
Duncan G. Johnson, Owensboro
Raymond E. Jones, Louisville
Irving F. Kanner, Lexington
Max D. Kline, Shelbyville
Robert C. Long, Louisville
Robert W. Lykins, Louisville
Paul F. Maddox, Campton
Owen B. Murphy, Lexington
P. A. Pichardo, Glasgow
F. M. Picklesimer, Paintsville
Nicholas J. Pisacano, Lexington
John C. Quertermous, Murray



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.







Photo professionally posed

Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —Pen•Vee® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections due to pathogens susceptible to oral penicillin G. Prophylaxis of rheumatic fever in patients with previous history of the disease.

Precautions: Skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin-allergy may occur. Measures for treating anaphylaxis should be readily available: epinephrine, oxygen and pressor drugs for relief of immediate allergic reactions; antihistamines and corticosteroids for delayed effects. Penicillin may delay or prevent the appearance of primary syphilitic lesions. Patients with gonorrhea who are suspected of concurrent syphilitic infections should be tested serologically for at least 3 months. Where lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. As with other antibiotics overgrowth of nonsusceptible organisms may occur; if so, discontinue and take appropriate measures. Treat β-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

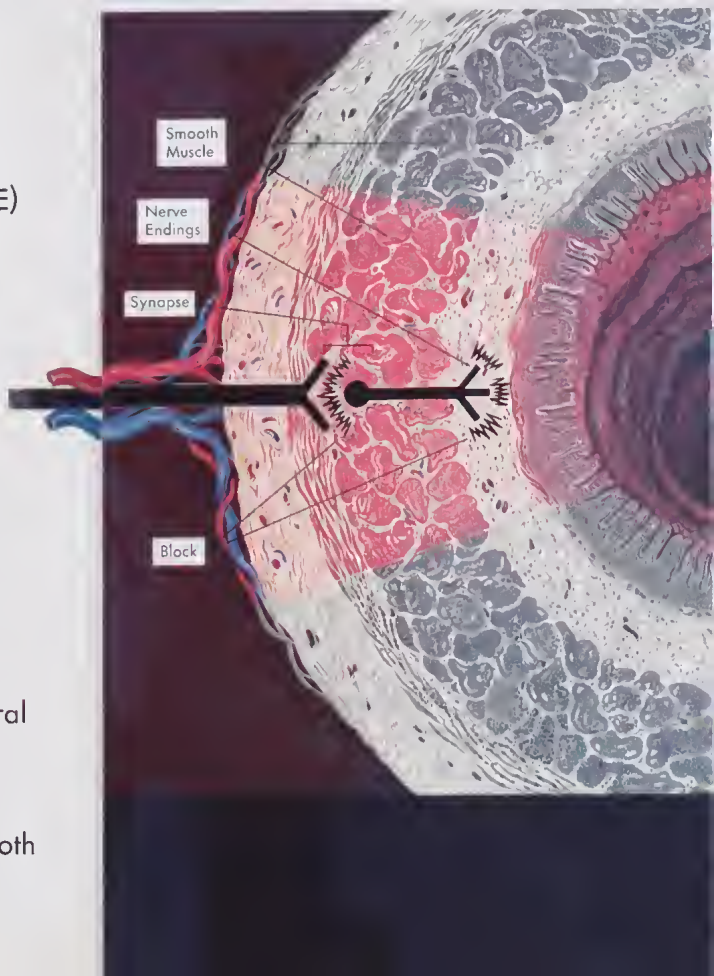
Composition: Tablets—125 mg. (200,000 units) and 250 mg., (400,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. **Wyeth Laboratories Philadelphia, Pa.**

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It works.

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How TREST®
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works.

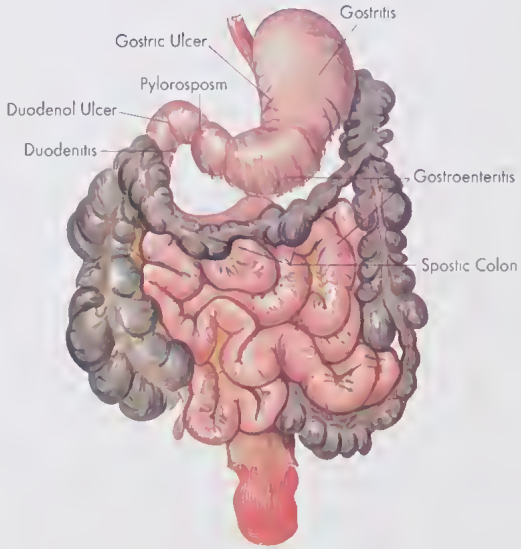


TREST (methixene hydrochloride) directly antagonizes the parasympathetic nervous system.

TREST (methixene hydrochloride) blocks the action of acetylcholine formed at the synapses and visceral parasympathetic nerve endings.

Therefore, nerve impulses are prevented from reaching the smooth muscle layer.

TREST® (METHIXENE HYDROCHLORIDE)
relieves gastrointestinal spasm, hyperactivity and associated pain in:



Put the gut to rest
with your prescription for
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Evidence that TREST®
(METHIXENE HYDROCHLORIDE)
works.

EFFECTIVENESS AND SAFETY
t.i.d. dosage in milligrams

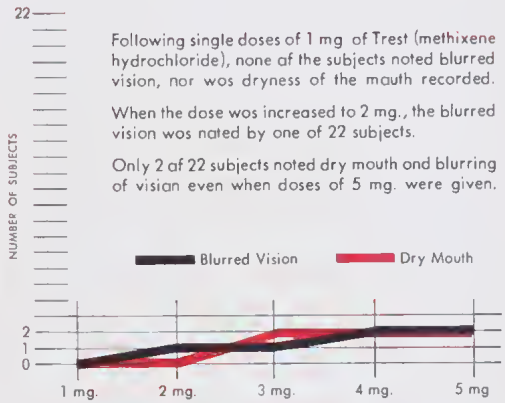
1 mg. symptamatic relief

2 mg. upper recammended clinical dase/greater pharmacalagic activity and symptamatic relief/side effects uncamman

10 mg.

Studies with 372 subjects revealed na adverse effect upan vital organs when dasage was increased 10 times the narmally effective dase af 1 mg. t.i.d. far periads up ta 2½ years af cantinued administratian.

LACK OF SIDE EFFECTS



Following single doses of 1 mg of Trest (methixene hydrochloride), none af the subjects noted blurred vision, nor wos dryness of the mauth recorded.

When the dose wos increased to 2 mg., the blurred vision wos nated by one of 22 subjects.

Only 2 af 22 subjects noted dry mouth ond blurring of visian even when doses of 5 mg. were given.

Conclusion: Typical atropine-like side effects are not expected when Trest is used 1 mg. t.i.d. These effects ore uncommon when the dosage is increased to 2 mg. t.i.d.

"A highly satisfactory symptomatic response was obtained in 20 of the 23 patients who took 1 mg. of methixene hydrochloride (Trest) by mouth three times daily. No side effects occurred at this dosage during administration of the medication itself.

"Methixene hydrochloride (Trest) provides highly gratifying symptomatic relief in a variety of conditions associated with gastrointestinal motility without producing the usual atropine-like side effects and without requiring concurrent barbiturate sedation."
—Martins, J. R.
Clin. Med. 72:1313-1316
(Aug.) 1965

"... in a series of 47 patients suffering from various types of functional bowel distress. The superiority of this drug (Trest) in dosage of 1.0 mg three times daily by mouth over the placebo is statistically significant. At that dosage level, side effects were not observed."
—Hufford, A. R.
Clin. Med. 72:1151-1155
(July) 1965.

SUMMARY:

TREST® (METHIXENE HYDROCHLORIDE)

relieves G.I. spasm, hyperactivity and associated pain by directly antagonizing the parasympathetic nervous system.

Each tablet contains methixene hydrochloride, 1 mg

INDICATIONS: Gastrointestinal Spasm and Hypermotility.

CONTRAINDICATIONS: Pyloric obstruction, gastric retention, obstructive organic disease of the gastrointestinal tract, organic cardiospasm, duodenal stenosis, stenosing peptic ulcer, and urinary bladder neck obstruction or prostatic hypertrophy are contraindications to the use of this drug.

WARNING: Overdosage produces anticholinergic side effects. Although the animal reproduction studies are negative, until there is clinical confirmation of safety in pregnancy, this product should not be used in women who may become pregnant unless in the opinion of the physician the benefits outweigh the risks.

PRECAUTIONS: Use only with caution in patients with certain types of cardiovascular disease, since anticholinergic drugs may cause arrhythmias. Extensive clinical studies of TREST have shown no evidence of glaucoma. However, the possibility exists that it can occur since it has been reported as a characteristic side effect of anticholinergic drugs. This product does not replace definitive treatment in organic gastrointestinal disease.

SIDE EFFECTS: Side effects are generally absent when TREST is used in the recommended dosage of 1 to 2 mg. three times daily. Uncommonly, allergy or sensitivity to the drug may be manifested by generalized rash or widespread desquamation. In case of prolonged or massive overdosage, dry mouth, blurred vision, and urinary retention, typical side effects common to anticholinergic drugs, may occur. Occasionally, sensitive patients may notice mild dryness of mouth or slight blurring of vision from doses of 2 mg. or more. Most patients tolerate single doses of 5 mg. without such side effects.

DOSAGE: The usual adult dosage is 1 mg. by mouth three times daily. If necessary, the dose may be increased to 2 mg. three times daily. Pediatric dosage has not been determined.

CAUTION: Federal law prohibits dispensing without prescription.

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Charles C. Rutledge, Hazard
J. Schicnel, Burkesville
J. Morton Schneider, Fort Knox
Donn L. Smith, Louisville
C. M. Steinfeld, Providence
David B. Stevens, Lexington
William R. Willard, Lexington
John D. Winebrenner, Louisville
Carroll L. Witten, Louisville
T. Julian Wright, Stanford

Occupational Health Conf. Set

The Third Governor's Occupational Health Conference will be held in Lexington, April 6, 1967. The full program and information concerning the conference will appear in the February issue of The Journal, Fred Blankenship, M.D., Louisville, Program Chairman said.

Dr. Coe Attends Heart Meeting

Walter S. Coe, M.D., Louisville, who is President of the Kentucky Heart Association, attended a meeting of officers of Heart Associations within the North Central Region, in Chicago on December 2. The purpose of the meeting was to discuss plans for the Heart Association's future growth and development. The North Central Region is composed of the Heart Association's in Kentucky, Indiana, Illinois, Ohio, and Michigan.

Dr. Witten Named to Task Force

Carroll L. Witten, M.D., Louisville, president of the American Academy of General Practice, was recently appointed a member of a national task force on the prevention and control of emphysema and chronic bronchitis. The task force is supported by the Chronic Respiratory Diseases program, U. S. Public Health Service, and is co-sponsored by the National Tuberculosis Association.
Council and Committee Reports

So. Med. Gyn. Group Elects

J. B. Marshall, M.D., Louisville, was chosen Chairman-Elect of the Section on Gynecology of the Southern Medical Association, in Birmingham, Ala., on December 9. Other officers elected to serve for the coming year are Richard G. Burman, M.D., Gulfport, Miss., Chairman; and Robert M. Ruch, M.D., Memphis, Tenn., Secretary.

Primarily a service organization for physicians, the Southern Medical Association is one of the largest organizations in the country, taking in sixteen southern states and the District of Columbia.

John F. Allen, M.D., Lexington, has been admitted into fellowship in the American College of Surgeons.



The above photograph, of three Western Kentucky Physicians, was snapped in South Vietnam late in November. At the left is George F. Broackman, M.D., Greenville, KMA President Elect who was serving a second tour of duty as a civilian physician under the AMA's "Project Vietnam". In the center is Elton R. House, M.D., formerly of Henderson, and on the right is James S. Brashear, M.D., formerly of Central City.

U of L Cancer Symposium Feb. 11

The Department of Surgery of the University of Louisville Medical School will hold a one-day symposium on "Diagnosis of Oro-Pharyngeal Cancer" on Saturday, February 11, in Rankin Amphitheater at General Hospital. Registration will begin at 8:30 A.M. Lunch will be served.

The program features seven leading authorities of national reputation in fields of surgery, dentistry, oto-laryngology, oral surgery, and radiotherapy. This symposium is open to all physicians, house physicians, dentists and related groups. Four and one-half hours credit will be allowed by the American Academy of General Practice.

Dr. C. F. Long, Dead at 72

Charles F. Long, M.D., Elizabethtown, a former vice-president of KMA, died at the age of 72, Tuesday, November 8. He was a trustee of Asbury College and a member of the State YMCA Board.

Industrial Group to Meet in N.Y.

The Industrial Medical Association and the American Association of Industrial Nurses have announced that the 1967 American Industrial Health Conference will be held April 10-13, at the Americana Hotel in New York City. The Conference, made up of the annual meetings of the two groups, will bring together about 2,500 persons from various public and industrial health fields.

The scientific program will be augmented by technical and scientific exhibits. For further information write the American Industrial Health Conference, 55 E. Washington St., Chicago 60602.



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

DOW PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

NOVAHISTINE® LP

For relief of nasal congestion.



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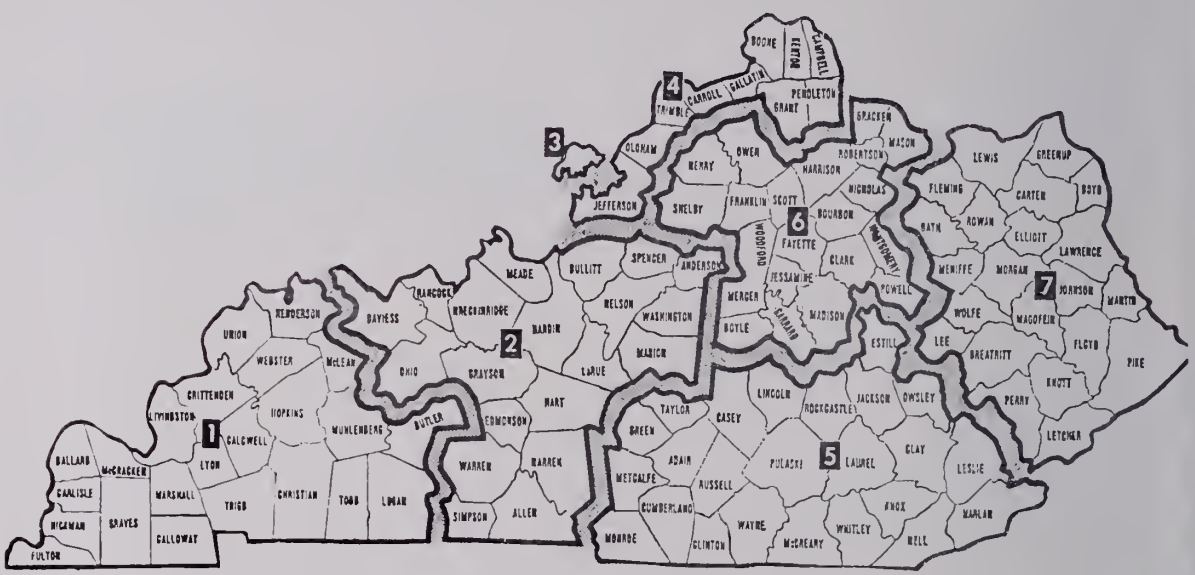
Numerous proposals which would change the pattern of medical care in this country will be presented to the 90th Congress during its current session. These are important to the public and medical profession.

For this reason, John C. Quertermous, M.D., Chairman of the KMA Council on Legislative Activities for National Affairs, asks all physicians to follow very closely developments in the months ahead.

Doctor Quertermous urges all physicians to become acquainted with their congressmen and points that the congressman is interested in having the views of his constituents.

The Journal of KMA, in order to assist you in accomplishing this, gives the following information for you. You may want to remove this page and keep it in your files. Your congressman may be reached by addressing him in Washington at the address listed below. The zip code for Washington, D. C. is 20002.

Kentucky's Seven Congressional Districts



CONGRESSMEN

District	Congressmen	Address
1	Frank A. Stubblefield (D), Murray	Room 1514 Longworth House Office Bldg.
2	William H. Natcher (D), Bowling Green	Room 2333 Rayburn House Office Bldg.
3	William O. Cowger (R), Louisville	Room 239 Cannon House Office Bldg.
4	M. G. "Gene" Snyder (R), Louisville	Room 1532 Longworth House Office Bldg.
5	Tim Lee Carter, M.D. (R), Tompkinsville	Room 1231 Longworth House Office Bldg.
6	John C. Watts (D), Nicholasville	Room 2411 Rayburn House Office Bldg.
7	Carl D. Perkins (D), Hindman	Room 2252 Rayburn House Office Bldg.

SENATORS

Senator	Address
John Sherman Cooper (R), Somerset	Room 125 Old Senate Office Building
Thruston B. Morton (R), Louisville	Room 437 Old Senate Office Building

Robert H. Coleman, M.D., Hopkinsville, has been reappointed, by Gov. Breathitt, to a second term on the Kentucky Human Rights Commission. The commission in the enforcement agency for the 1966 State Civil Rights Law prohibiting racial discrimination in public accomodations and employment.

A portrait of Edward H. Ray, M.D., Lexington, Chief of the Department of Urology at the University of Kentucky Medical Center, has been dedicated and is now hanging in the university auditorium.

KMA Council and Committee Reports

Council on Scientific Assembly

Robert E. Pennington, M. D., London, Kentucky, Chairman

KMA Headquarter Office **October 27, 1966**

The KMA Council on Scientific Assembly met soon after the 1966 Annual Meeting to plan next year's Annual Session which is scheduled for September 26-28, 1967.

General plans for all business and scientific activities associated with the Annual Meeting were outlined for 1967, and the details for all scientific sessions were referred to the Scientific Program Committee. Request from allied groups to schedule functions during the 1967 Annual Meeting were considered and times assigned for such activities were made as felt appropriate by the council members.

The 1967 Annual Meeting again will be held at the Convention Center in Louisville with the Kentucky Hotel being the headquarters hotel.

Scientific Program Committee

Roderick Macdonald, Jr., M. D., Louisville, Chairman

KMA Headquarters Office **November 10, 1966**

The KMA Scientific Program Committee met recently to plan the scientific sessions for the 1967 KMA Annual Meeting, September 26-28. General sessions were planned for Tuesday morning, all day Wednesday, and Thursday morning. Specialty groups were scheduled to have sessions on Tuesday and Thursday afternoons.

In formulating a diversified program, the committee planned to present a taped color TV session, a tele-lecture or transatlantic program to be sponsored by Smith, Kline, and French Laboratories and outstanding papers on subjects within specific themes established for the four one-half day sessions.

It was agreed that final arrangements for scientific sessions would be made on December 7 when the presidents of all specialty groups participating in the 1967 Annual Session would meet with the KMA President and Chairman of this committee.

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman, National Affairs

Fred C. Rainey, M.D., Elizabetltown, Chairman, State Affairs

KMA Headquarters Office **November 16, 1966**

The Council on Legislative Activities held its first meeting for the new associational year on Wednesday, November 16, at which time legislation at the last congress was reviewed and possible pending legislation before the 90th Congress was discussed.

Plans were made for future activities of the Council, with a number of recommendations being passed for consideration by the KMA Board of Trustees.

Highway Safety Committee

William K. Keller, M.D., Louisville, Chairman

KMA Headquarters Office **November 30, 1966**

The Kentucky Medical Association Automotive Safety Award was presented to Colonel James E. Bassett, Director of Kentucky State Police, at the Highway Safety Committee meeting at KMA Headquarters on November 30, 1966. William K. Keller, M.D., Louisville, chairman of the KMA Highway Safety Committee, presented the award for the committee. The award was made in recognition of a state police rule requiring all troopers to wear seat belts while driving.

"The KMA Award is given to any group or organization which gets 100 percent of its members to have seat belts installed in every car operated by the membership," Doctor Keller said.

"The objective of this committee is to decrease deaths and disabilities caused by motor vehicles," Doctor Keller said. On this premise the committee received the announcement of the new Kentucky-Cornell ACIT (Automotive Crash Injury Research) Program starting January 1, 1967. This program is a study of accidents involving late model passenger cars. The new 1966 federal legislation for auto safety, PL 89-563, The Traffic Safety Act, and PL 89-564, The Highway Safety Act, were discussed.

Mental Health Committee

Logan Gragg, Jr., M.D., Chairman, Lexington

KMA Headquarters Office **December 1, 1966**

At their initial meeting of the associational year at KMA Headquarters on December 1, 1966, the KMA Mental Health Committee re-defined and adopted their duties recognizing that alcoholism is now one of their direct responsibilities. This duty was formerly handled by the sub-committee, Logan Gragg, Jr., M.D., Lexington, chairman of the committee noted.

Frank M. Gaines, M.D., Louisville, made a report to the committee on the National Conference of the American Association of General Practice and the American Psychiatric Association. He further related the national activities to those within Kentucky indicating that state interests normally run along the same line.

In view of different attitudes developing on treatment of drunkeness and alcoholism as an illness requiring medical treatment rather than penal action, Dale M. Farabee, M.D., Commissioner, Kentucky Department of Mental Health, appearing as a guest of the committee, urged that the committee and medicine search for new ideas and approaches to the alcoholism problems.

After making committee plans for activities of their concern, the next committee meeting was scheduled for February 9, 1967.



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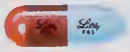
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COUNTY SOCIETY REPORTS

McCracken

The regular meeting of the McCracken Medical Society was held at Boswell's Restaurant on the afternoon of November 16, 1966.

The scientific part of the meeting was presented by William Hosback, M.D., the Program Committee Chairman. He introduced Kirk O. Metzerott, M.D., Staff Anesthetist of Norton Infirmary, Louisville. H's subject was "The Use of Balanced Fluid in Replacing Extra-Cellular Fluid Loss During Surgical Procedures".

Following the scientific portion of the meeting, the business meeting was called to order at 8:30 P.M. by the President, Walter Johnson, M.D.

APPOINTMENT OF NOMINATING COMMITTEE: This final act of business was performed by the President, when he appointed William Myre, M.D., Bill Hosback, M.D., Charles Harting, M.D., and Gene Sloan, M.D., as the nominating committee to prepare a slate of officers for the next year. The Secretary was advised to attend this meeting.

The meeting was adjourned about 9:20 P.M.

NEWS ITEMS

Mehmet Arik, M.D., Louisville, former chief of the medical staff at Central State Hospital in Anchorage, has replaced William J. Kernahan, M.D., as superintendent of Kentucky State Hospital in Danville. Doctor Arik graduated from the University of Istanbul in 1946 and has been with Central State Hospital since 1957.

B. F. Reynolds, M.D., Carlisle, is retiring after 50 years of practice. He graduated from the University of Louisville School of Medicine in 1903, and has served as Health Officer for Nicholas and Bath Counties since 1959.

Mitchel B. Denham, M.D., Maysville, was named by the governor to a three-man committee formed to study mental health problems in Kentucky.

Gladys Rouse, M.D., Florence, long-time Boone County Medical Society Secretary, has been recognized by her fellow citizens on her retirement after forty years of service.

M. Gaynor Howell, Jr., M.D., has started practice in association with the Henderson Clinic, Henderson, Kentucky. Doctor Howell will limit his practice to obstetrics and gynecology. He graduated from the University of Tennessee Medical School in 1960, finished his internship at the Baroness Erlanger Hospital, Chattanooga, in 1961, and completed his residency at the University of Tennessee Memorial Research Center and Hospital, Knoxville, in 1966.

Becky John, M.D., Hindman, a 1965 graduate of the University of Louisville Medical School, is now associated with the Knott County Health Department. She took her internship at Tucson Medical Center and Pima County General Hospital, completing it in 1966.

W. H. England, M.D., general practitioner, has started practice in Grand Rivers, Kentucky. Doctor England graduated from the University of Tennessee Medical School in 1951, completed his internship at Baptist Hospital, Memphis, in 1952, and his residency training in 1953. He has previously practiced in Lone Oak and Barlow, Kentucky.

In Memoriam

FRANK M. POWELL, M.D.
Louisville, Ky.
1916 - 1966

Frank M. Powell, M.D., 50, Louisville general practitioner, died December 2 at his home. Doctor Powell had practiced in the Louisville area for twenty years. He graduated from the University of Louisville Medical School in 1940 and was a captain in the Army Medical Corps during WWII. Doctor Powell was a member of KMA.

EDWARD J. MURRAY, M.D.
Lexington, Ky.
1885 - 1966

Edward J. Murray, M.D., Lexington, 81, superintendent for 38 years of the old Julius Marks Sanatorium, Lexington, died on November 25. He graduated from the University of Colorado School of Medicine in 1914, and was a past president of the Fayette County Medical Society.

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this issue: the nose as a shock organ

the nose as a shock organ

by Charles J. Shagoury, M.D., Chelmsford, Massachusetts



"Is it a cold, hay fever, or has he been reprimanded by his boss?" Occasionally, you will ask yourself this question when confronted by a patient with abrupt onset of rhinorrhea, nasal obstruction, and sneezing. Usually the history will elucidate the problem, but examination of the nose will often provide valuable clues to the correct diagnosis.

The nose is a shock organ in a double sense. First, it is in the nose that the confrontation takes place with the surrounding atmosphere. For twenty-four hours a day, the nose must meet the varying challenges of the inspired air, containing perhaps noxious chemicals, dust, dirt, bacteria, viruses, fungi, and industrial pollutants of all kinds, and render it clean, virtually sterile, and fit for the sensitive alveoli of the lungs. Whatever the temperature or humidity of the atmosphere, the nose must transmit it to the lungs at approximately 98°F, and with a humidity of approximately 40%.[1]

Second, in particularly susceptible patients, the nose acts as a shock organ in a manner totally unrelated to its normal function. Persons with hay fever respond to ordinarily harmless materials by extreme nasal congestion, with marked rhinorrhea and violent spasms of sneezing. In some patients, exposure to threatening or disagreeable agents, or situations involving mental conflict may result in a reaction which is exclusively nasal, with swelling of the turbinates, and marked hypersecretion.[2]

Nasal symptoms usually result when the nose seeks to perform its function of getting rid of noxious and dangerous elements in the atmosphere, and prevent their admission to the trachea and lungs. Small particles are removed by the mucous coating which blankets the nasal passages. This mucous blanket contains a bacteriostatic agent, lysozyme, which destroys most air-borne bacteria.[3] The mucinous content renders the surface sticky, causing dusts and small particles to adhere. It has been postulated that this process is rendered more effective through adsorption because of a surface electrical charge on the nasal mucosa.[4] The cilia then sweep the particulate matter to the pharynx. The nose can prevent entrance into the lungs of particles as small as three microns in diameter, but smaller particles elude the nasal barrier. Most bacteria causing respiratory infections are one to three microns in diameter, but since they usually are inhaled in clumps, they are efficiently removed as a rule. Viruses, which are of the order of 1/1000 of this size, are less efficiently dealt with, unless they occur in very large aggregates.[5]

The nose will react in a more or less similar manner, whatever the nature of the offending agent, whether it be an irritant chemical, virus, pollen, or distasteful emotional situation. In acute coryza, the most characteristic sign is a profuse watery discharge. The volume of secretion may rise from practically nothing to nearly 60cc in twenty-four hours.[6] The mucous membrane is reddened and engorged, while the turbinates are markedly swollen. After the first day or two, the secretion becomes thicker, yellowish, and more difficult to expel. The surface cells are largely destroyed, contributing to the copious discharge, which now also contains numerous inflammatory cells which have migrated to the area. Gradually, over a period of a few days, or a week, the flood abates, the swelling and redness subside, and the nasal epithelium resumes a healthy appearance.

Repeated attacks of rhinitis, particularly if there is an underlying element of obstruction, may result in chronic rhinitis. The mucous membrane is constantly swollen and reddened. Sticky, mucopurulent secretions are a continuous feature, and the glandular elements are hypertrophied. Commonly, the mucosal surface takes on an irregular, rounded "mulberry" appearance, and nasal passages are occluded by the swollen turbinates and redundant mucosa.

While all of us are susceptible to colds, the victim of hay fever, or allergic rhinitis, displays a marked nasal reaction to materials in the air which leave his associates unaffected. In such a patient, the nasal mucosa has become an allergic "shock" organ. Contact with the nasal allergen causes local release of histamine, with vasodilatation, increased vascular permeability, and severe nasal congestion, similar to the "wheal" and "flare" reactions in the skin, when the epidermis is the allergic shock organ. While we eagerly await the coming of spring, the hay fever sufferer dreads the blooming season, whose invisible pollens are poisons to his sensitive nose. His neighbor's cat or dog may provoke paroxysms of uncontrollable sneezing. In some cases a specific allergen is not identified, but the triad of rhinorrhea, nasal obstruction, and sneezing is present.[7] The nose in these cases shows a pale, boggy, edematous mucosa, with a thin mucoid secretion. The mucous membrane shows extreme retractility to 1% cocaine or ephedrine. If the patient has medicated himself prior to examination, the nasal passages may appear abnormally patent, or show exaggerated congestion due to rebound reaction. The secretion may show a large number of eosinophils particularly after an attack of sneezing or rhinorrhea. Touching the mucosal surface, especially of the inferior turbinate, leaves an indentation, showing that the swelling is due to stasis and edema, rather than actual hyperplasia of the mucous membrane as in chronic hypertrophic rhinitis. Though the pale swollen mucosa is the hallmark of allergic rhinitis, as usually seen by the physician, exposure of allergic subjects to their known allergens results in a brief hyperemic phase, followed by pallor and edema.[8]

In the later stages of allergic rhinitis, the chronic edema of the mucous membrane results in the formation of polyps, clusters of grape-like masses hanging from the roof of the nose, with a pale glistening surface, contributing significantly to the sense of nasal obstruction and oppression.

A large group of patients show symptoms of nasal congestion when confronted by adverse life situations.[9] In these unfortunate persons, anxiety, frustration, and resentment are often accompanied by a runny nose and nasal obstruction. Lacrimation adds to the nasal stuffiness. This autonomic response, mediated by the parasympathetic nervous system, may be part of a general parasympathetic reaction, or may possibly represent in part, a symbolic effort to wash out and crowd out the offending situation.

Nasal congestion may also occur in some patients at times of sexual stimulation, and in women during menstruation and pregnancy, even to the point of epistaxis.[10] The relationship is obscure; castration results in atrophy of the nasal glands, and their action is inhibited by the hormones of the hypophysis and the thyroid.[11] The nose may be the shock organ in drug therapy. The nose may also bear the brunt of industrial stress, in those who work in a hot dry atmosphere, or those exposed to acid fumes, or irritating dusts. As the air in our cities is increasingly polluted by exhaust fumes, and industrial irritants, whole urban populations may suffer from chronic nasal and respiratory symptoms.

Of course, nasal reactions are not just infectious, or allergic, or emotional. Particularly in the chronic sufferers, there is an interdependence of all three. Death of a relative, or other psychic shock can pre-

(concluded on following page)

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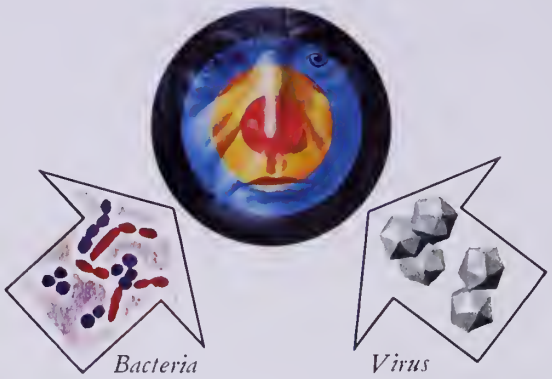
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cipitate an attack of rhinorrhea in hay fever sufferers.[12] Others develop attacks of vasomotor rhinitis following change in temperature, chilling, or exposure to the sun, or simply warm bedclothes.

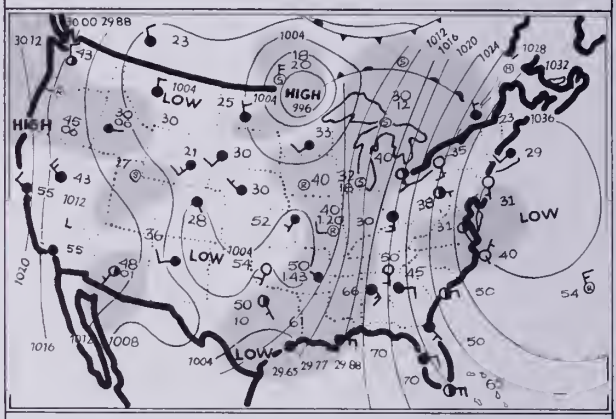


The complex interplay of allergy and infection is largely unclear. Allergy to the viruses and bacteria which cause infection has been postulated, but is difficult to demonstrate. The swollen obstructed allergic nose is more susceptible to infection. At the same time, infection often precedes or precipitates an allergic attack. Exposure of a susceptible patient to an allergen can activate latent virus organisms leading to infection.[13] This "jolt" reaction represents a summation of an allergen and a virus leading to symptoms in the nose as a shock organ, which neither could have produced alone. In childhood, repeated attacks of bronchitis and colds may be inflammatory reactions to an allergen, or precipitated by exposure to an allergen. These children may later develop typical allergic rhinitis. On the other hand, children with typical allergic histories, eczema, asthma, and allergic familial backgrounds, may later develop typical infectious rhinopathies. Skin tests in such patients are usually positive.

Nasal reactions are part of the systemic response of the patient to an unwelcome stimulus. In cases of respiratory infection and exposure to atmospheric irritants, the reactions are useful, and to some extent desirable. They are usually self-limited, disappearing within a few days, or upon removal of the provoking agent. Here the distressing symptoms can be ameliorated with appropriate decongestant agents, or, in the case of severe or complicated respiratory infections,antibiotics may be given, with reasonable confidence of a cure. On the other hand, when nasal reactions are the peculiar response of an individual to an allergen, or to an undesirable situation, they serve no useful purpose. The nose here is a shock organ in a stressful situation, but can furnish no response of value. It merely causes the patient symptoms which add to his problems. In these cases, symptomatic treatment is of great benefit, but often the underlying faulty pattern of response cannot be altered. Such a patient may literally be considered to be paying his way in life "through the nose."

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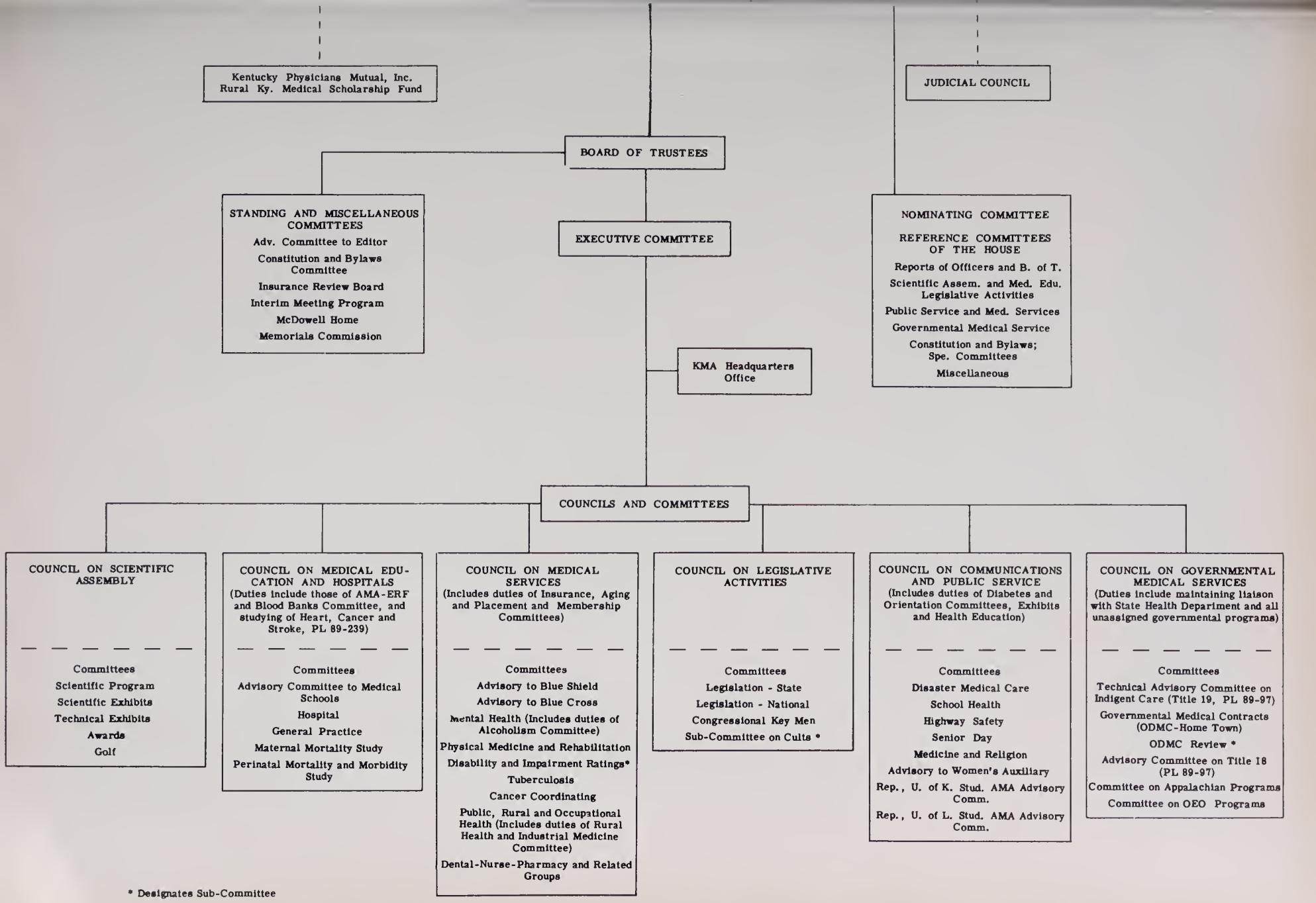
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KMA Organization Chart—Revised September 21, 1966

PUBLIC HEALTH PAGE

The Role Of The Home Health Agency In Health Care For Our Citizens

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

WITH the passage of Public Law 89-97 by the Congress in July, 1965, provisions were made for the certification of institutions that met the definition of a "home health agency" for purposes of Title XVIII of the Act. The term "home health agency" is defined as being "a public agency or private organization or a subdivision thereof which is primarily engaged in providing skilled nursing services and other therapeutic services, has policies established by a group of professional personnel, maintains clinical records on all patients, meets the requirements of state and local laws, and meets such other conditions of participation as the Secretary of Health, Education and Welfare may find necessary in the interest of the health and safety of the individuals who are to be the beneficiaries of the services furnished by such an agency." The other requirements for participation are incorporated into the "Conditions of Participation for Home Health Agencies".

Examples of agencies which might possibly be eligible for participation in the Health Insurance Benefits Program as home health agencies are a visiting nurse association, a subdivision of a local or state health department offering home health services, or a department of a hospital, medical school, medical clinic, extended care facility or rehabilitation facility offering home health services.

The term "home health services" is defined as services rendered by an agency that furnishes specific items and services to an individual, who is under the care of a physician, by a home health agency or by others through arrangements made by such agency under a plan established and periodically reviewed by a physician.

In the Commonwealth of Kentucky, the Department of Health was designated as the State Agency to assist the Department of Health, Education and Welfare in determining whether or not the statutory requirements and conditions of participation are met by those agencies desiring to become home health agencies and provide home health services within the meaning of the Social Security Act. These determinations are made by a team of qualified professional personnel who make on-site visits to potential providers of home health services. Following an on-site visit, recommendations for certification or denial are made, based upon the findings of the survey team.

In addition to certification visits, upon request, many consultation visits are made to these potential providers of home health services. The purpose of these visits is to provide information and guidance for the establishment of a home health agency and to discuss with persons in the medical, nursing and related fields the role of the home health agency in the total picture of health care.

As of December 1, 1966, three home health agencies in Kentucky have been certified and have been participating in the Health Insurance Benefits Program almost from its beginning; July 1, 1966. Two of these agencies were in existence prior to the birth of Medicare. One agency is a newly organized one.

Obviously, this is a relatively new field of health care for most areas of Kentucky; however, it is gratifying to know that the need for home health services is recognized as an important part of patient care. The exploration of ways and means of providing these services,

(Continued on page 102)

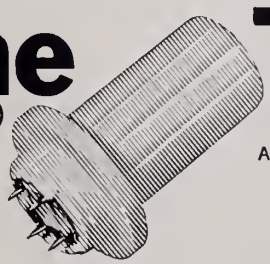
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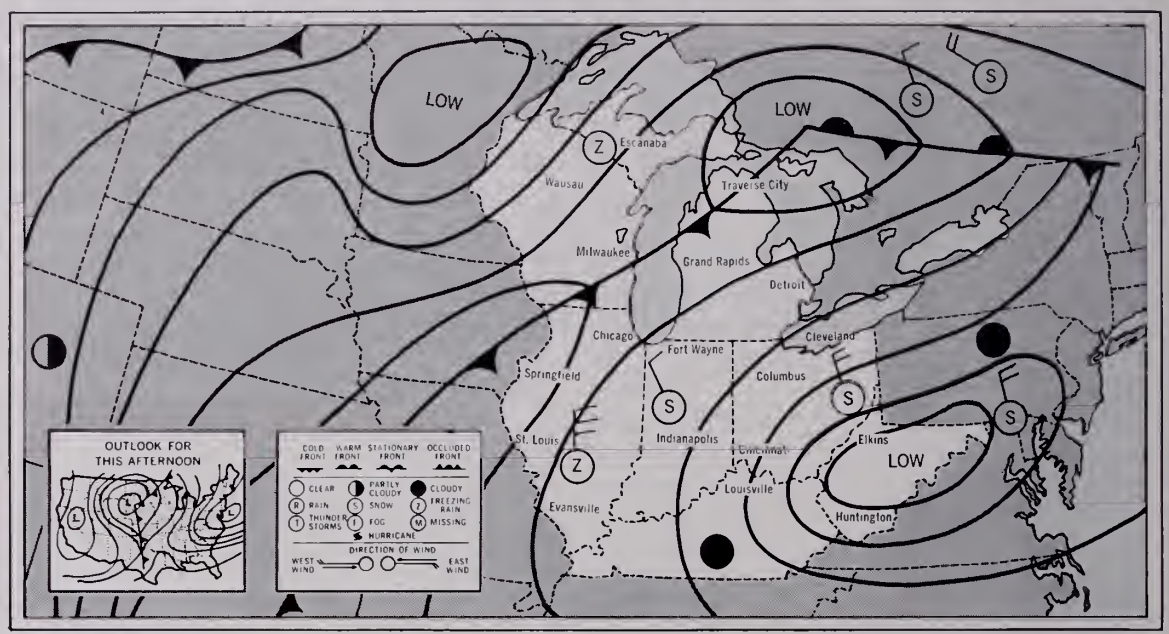
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Senior Day Committee

Hoyt D. Gardner, M.D., Chairman, Presiding

KMA Headquarters — November 10, 1966

The KMA Senior Day Committee, at its November 0 meeting, outlined Senior Day programs for the University of Louisville and the University of Kentucky Senior Medical Students. It has decided that the thirteenth annual U of L program would be presented in Louisville March 20 and the fourth annual U of K program in Lexington April 11.

These annual affairs are sponsored by KMA in cooperation with the Jefferson County and Fayette County Medical Societies. Each features outstanding guest speakers at the program's closing dinner, in addition to presentations by numerous KMA members throughout the day. It was agreed that the format used in previous years would be followed again in 1967.

Council on Medical Services

George W. Pedigo, M.D., Louisville, Chairman, Presiding

KMA Headquarters Office — November 17, 1966

At their initial meeting under the new KMA organization structure approved by the House of Delegates in September, the members of the Council on Medical Services discussed in detail their duties and assigned programs and made plans for the 1966-67 associational year. In addition, action was taken on specific matters referred to the council and the possible activities for the committees serving under the council were considered.

The council members expressed their interest in the socio-economic field and recommended that they receive a report of the AMA Socio-Economic Congress to be held in Chicago in January at their next meeting. Dates set for future meetings of the council are February 9 and June 15, 1967.

Physical Medicine and Rehabilitation Committee

William K. Massie Jr., M.D., Lexington, Chairman, Presiding

KMA Headquarters — November 23, 1966

The Physical Medicine and Rehabilitation Committee held their first meeting of the new associational year on November 23, 1966, at KMA Headquarters.

William K. Massie, Jr., M.D., Lexington, chairman of the committee, reviewed the past activities of the committee. Plans and assignments of tasks to committee members for the 1966-67 associational year were announced.

Of major importance to the committee are the development of studies and recommendations for the improvement of the administration of the workmen's compensation laws in Kentucky, Doctor Massie said. Among the goals of the committee are hopes of attaining better utilization of the physically handicapped on productive tasks within their capability. The next meeting date of the committee was scheduled for May 4, 1967.

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KMA Postgraduate Medical Education Office

The staff of Louisville's Methodist Evangelical Hospital and the University of Louisville School of Medicine will present the Second Postgraduate Day on Wednesday, January 25 from 8:30 A.M. to 5:00 P.M. William Crosby, M.D., Tufts New England Medical Center, Boston, and Hugh Chaplain, M.D., Washington University School of Medicine, St. Louis, will be the principal visiting guest speakers. Moderator of the program, which will be held in the Classroom of the Methodist Evangelical Hospital, will be Marion Beard, M.D., Louisville.

IN KENTUCKY

JANUARY

25 Second Annual Postgraduate Day, "Modern Concepts of Blood Disease", Methodist Evangelical Hospital and the University of Louisville School of Medicine, Methodist Hospital, Louisville.

MARCH

15-17 Recent Advances in Pediatric Clinical Pathology, University of Kentucky Medical Center, Lexington.

23-25 Fifth Annual Postgraduate Seminar for Pediatricians, University of Kentucky Medical Center, Lexington. ($35.00 fee)

APRIL

22 Industrial Doctors and Nurses, Executive Inn, Louisville. (All day meeting).

IN SURROUNDING STATES

JANUARY

18-19 Cleveland Clinic Educational Foundation (Course in General Surgery), Bunts Auditorium-Educational Building, Cleveland.

23-25 Society of Thoracic Surgeons, Muehlback Hotel, Kansas City, Mo.

31 Feb. 4 American College of Surgeons, Los Angeles.

FEBRUARY

1-2 Cleveland Clinic Educational Foundation (General Practice), Bunts Auditorium, Cleveland, Ohio

8-10 American Academy of Occupational Medicine, San Francisco Hilton Hotel, San Francisco.

9-15 Congress of Medical Education, Palmer House, Chicago

15-19 American College of Cardiology, Washington Hilton Hotel, Washington, D.C.

23-25 American Academy of Pediatrics, Boston Lying-In-Hospital, Boston

26-March 4 American Society of Clinical Pathologists, Dunes Hotel, Las Vegas

MARCH

8-9 Cleveland Clinic Educational Foundation, "Advances in Urology", Bunts Auditorium, Cleveland, Ohio

9-11 American Academy of Pediatrics, University of Tennessee College of Medicine, Memphis

10-11 20th. National Conference on Rural Health, Queen Charlotte Hotel, Charlotte, N.C.

10-12 American Association of Pathologists and Bacteriologists, Sheraton-Park Hotel, Washington, D.C.

29-30 Cleveland Clinic Educational Foundation, "Medical Progress and its Relationship to Dentistry", Bunts Auditorium, Cleveland

30-April 1 American Academy of Pediatrics, Stanford University of Medicine, Palo Alto, Calif.

APRIL

3-7 40th Annual Spring Congress in Opthalmology and Otolaryngology, Gill Memorial Ear, Eye and Throat Hospital, Roanoke, Virginia

5-6 Cleveland Clinic Educational Foundation, "Diagnostic Procedures in Gastroenterology", Bunts Auditorium, Cleveland

10-13 Industrial Medical Association, Americana Hotel, Bal Harbour, Fla.

10-13 So. Western Surgical Congress, Del Webb's Towne House, Phoenix, Ariz.

15-16 19th Annual Joseph and Samule Freedman Lectures in Diagnostic Radiology, University of Cincinnati College of Medicine.

Governmental Medical Contracts Committee (ODMC-Home Town)

L. Douglas Atherton, M.D., Chairman

KMA Headquarters Office **Wednesday, Nov. 30, 1966**

The Governmental Medical Contracts Committee (ODMC-Home Town) chairman and several committee members met with General Norman E. Peatfield, Executive Director of the office for Dependents' Medical Care of Denver, Colorado, on November 3, 1966. Bad weather prevented other members of the committee from attending. At this meeting, General Peatfield advised that Congress accepted the concept of usual and customary fees in the expanded portions of the contract and advised that future contracts with the Association are to be negotiated on this basis.

At the meeting on November 30, 1966, the present and expanded portions of the contract were reviewed with committee members. Also reviewed was the VA Home Town Care Contract to be renegotiated on a usual and customary basis.

Committee on OEO Programs

Harry U. Whayne, Jr., Chairman

KMA Headquarters Office **Thursday, December 8, 1966**

The Committee on OEO Programs held its first meeting on December 8, 1966, which was primarily for orientation. The committee discussed in detail the OEO programs in existence in Kentucky and particularly stressed the Community Action Programs.

Council on Communications and Public Service

N. Lewis Bosworth, M.D., Lexington, Chairman, Presiding

KMA Headquarters Office **December 7, 1966**

The Council on Communications and Public Service recently held its initial meeting of this Associational Year, considered their revised duties under the new KMA organizational structure, and outlined plans for the months ahead, both at the Council level and with the Committees serving under this Council.

Special emphasis at the meeting centered around careers and the shortage of allied health personnel, and a recommendation was submitted to the KMA Board of Trustees that a new Committee be appointed under this Council to stimulate careers in the health field. Other recommendations made called for the establishment of a Speaker's Bureau and the elimination of the present Diabetes Detection and Education Program since a year-round program is now conducted by the State Department of Health.

The presentation of KMA exhibits at the KEA Annual Meeting and State Fair during 1967 were approved, and plans for the fourth KMA Orientation Program to be held in April were finalized. The Council scheduled another meeting to be held in July.

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Neomycin rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Neo-Synalar under certain conditions. **Availability:** Neo-Synalar Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. **2.** Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

Doctor Rash Dies at Age 90

O. W. Rash, M.D., who practiced medicine in West Kentucky for 67 years, died at Owensboro on November 22. A graduate of the Louisville College of Medicine in 1897, he started practicing in Madisonville and moved to Owensboro in 1900.

When he retired in 1964, as far as the records indicated, he had been in practice longer than any other Kentucky physician. He was a member of the American College of Surgeons and a former president of the Daviess County Medical Society.

Public Health Page *(Continued from page 92)*

and the availability of trained personnel to render them has aroused the interest of both hospitals, county health departments and those in the medical profession. There is no doubt that this health service will play a prominent part in the medical care offered to our citizens in the years that lie ahead, and that Kentucky can look forward to the fulfilling of the needs of her people who require home health services.

Pacemaker Therapy *(Continued from page 29)*

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25. Brockman, S. L., et al.: *Physiological Studies and Clinical Experience in Patients with Synchronous and Asynchronous Pacemakers.* J. Thoracic and Cardiovas. Surg. 51:864-872 (June) 1966.
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27. Parsonnet, V., Zucker, I. R., Gilbert, L. and Myers, G. H.: *Clinical Use of an Implantable Standby Pacemaker.* J.A.M.A. 196:784-786 (May 30) 1966.
28. Ellis, F. H., Jr., Manning, P. C., Jr. and Connolly, D. C.: *Treatment of Stokes-Adams Disease.* Mayo Clinic Proceedings 39:945-953, 1965.

The drug industry has made significant contributions to our ability to care for the sick, done basic and worthwhile research in our behalf, and with our help as physicians, is a private enterprise for which we should be grateful. For the things I dislike about some of their products, the men who represent them, and for some of their overly enthusiastic claims, I shall continue to make my complaints to the drug companies themselves, not to my fellow physicians. For the many more things that they have done to augment my practice in a wholesome and worthwhile way, I shall continue to support them. In the overall picture, the ethical drug companies are our allies in the private and public practice of medicine.—P. A. Overstreet, M.D., in *The Internist,* (7:8), June-July 1966.

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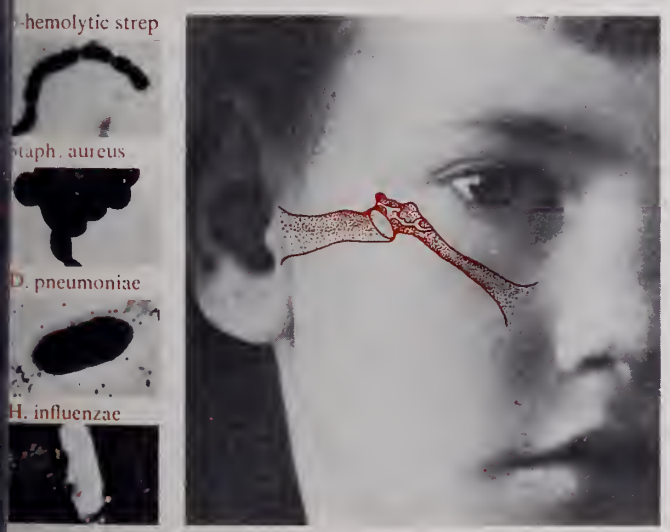

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Precautions: Observe usual sulfonamide therapy precautions, including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus or rickettsial infections.

Adverse Reactions: Following may occur: headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Dosage: Children—1 teasp./20 lbs initially, followed by ½ teasp./20 lbs b.i.d. *Adults*—4 teasp. initially, followed by 2 teasp. b.i.d. or t.i.d., depending upon severity of infection.

How Supplied: Suspension 10%, 0.5 Gm sulfamethoxazole/5 cc teasp., cherry-flavored, bottles of 16 oz.

References: 1. Braden, B.; Colmore, J. P., and Cummings, M. M.: Antimicrobial Agents Annual—1960, p. 54. 2. Alban, J.: *Am. J. Dis. Child., 109*:304, 1965. 3. Elia, J. C.: *Eye Ear Nose & Throat Month., 41*:722, 1962. 4. Carter, C. H.: *Clin. Med., 71*:1571, 1964. 5. Jackson, H.; Cooper, J.; Mellinger, W. J., and Olsen, A. R.: *Southwestern Med., 44*:246, 1963. 6. Reichelderfer, T. E.: *Clin. Med., 71*:1045, 1964. 7. Peters, J. H.: Scientific Exhibit presented at the Spring Meeting of the American Academy of Pediatrics, April 26-29, 1965. 8. Peters, J. H.: Antimicrobial Agents and Chemotherapy—1961, p. 406. 9. Braden, B., and Colmore, J. P.: *J. Oklahoma M. A., 57*:7, 1964. 10. Chastain, P. J.: *J. Florida M. A., 48*:816, 1962. 11. Grater, W. C.: *Antibiotics & Chemother., 12*:450, 1962. 12. Exline, A. L.: *Colorado GP, 5*:(5), 11, 1963. 13. Patton, J. M.: *West. Med., 5*:46, 1964.

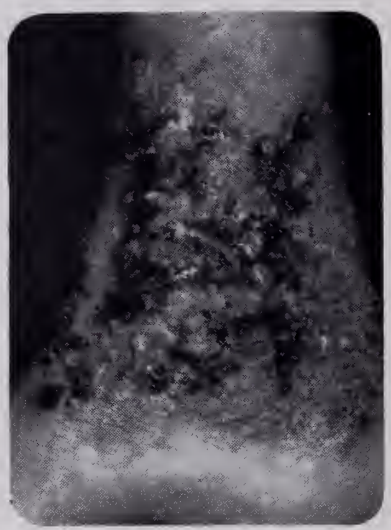
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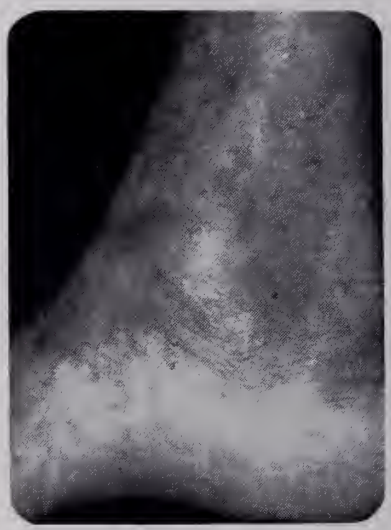
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Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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THE INSURANCE PAGE



Health Insurance Accreditation

AT the recent A.M.A. meeting in Las Vegas, the concept of voluntary health plan accreditation was again discussed in detail. At the June 1966 meeting a resolution proposed the formation of a joint commission for accreditation of voluntary health insurance plans similar to the joint commission for the accreditation of hospitals.

The resolution pointed out that a multiplicity of health insurance programs are offered to the public, and some of these programs are definitely inferior in type and scope of benefits provided. The purchaser at times does not enjoy the protection he believes he has obtained. Patients frequently seek the advice of their personal physicians on specific policies and coverages. It is not possible for physicians to be familiar with the many details of coverage in the wide variety of contracts on the market. We, therefore need some means of evaluating various plans for the benefit of our patients, and as a means of eliminating substandard carriers who are unwilling to provide adequate levels of coverage.

Reputable insurance companies and the public have as great an interest in health insurance operations as do physicians. The Health Insurance Council, The National Association of Blue Shield Plans, The Blue Cross Association, and other insurance organizations have joined with the A.M.A., A.A.G.P., The American Society of Internal Medicine and other interested medical organizations in studying the formation of a joint commission for the accreditation of health insurance plans.

The commission would operate to set standards, examine the extent of coverage and investigate other pertinent details of health plans. Upon the satisfaction of such requirements as would be deemed appropriate the commission would issue certificates of approval for those plans that voluntarily apply and are approved. The cost of operation would be met by application fees collected from the plans seeking accreditation.

In August the initial planning conference was held in Chicago. Comments by the meeting participants reflected a variety of reactions to the proposal. The medical participants were unanimous in support of the concept that such a program is needed and is feasible. Spokesmen for the carriers were interested but expressed some reservations about the mechanics of operation of the commission. It was pointed out that the establishment of specific standards might compel a degree of uniformity in rates and benefits which would discourage active experimentation in developing wider benefits. Also mentioned was the serious possibility that a charge of conspiring to restrain trade and commerce could result.

The recitation of difficulties involved in formulating qualifying standards and the various legal hazards involved emphasized the complex and far reaching impact such a certifying program would exert on the health insurance industry. In view of these difficulties, it was recommended that the formation of the joint commission not be attempted at this time, but that the subject continue to be actively studied and data be developed for future use in establishing such a program.

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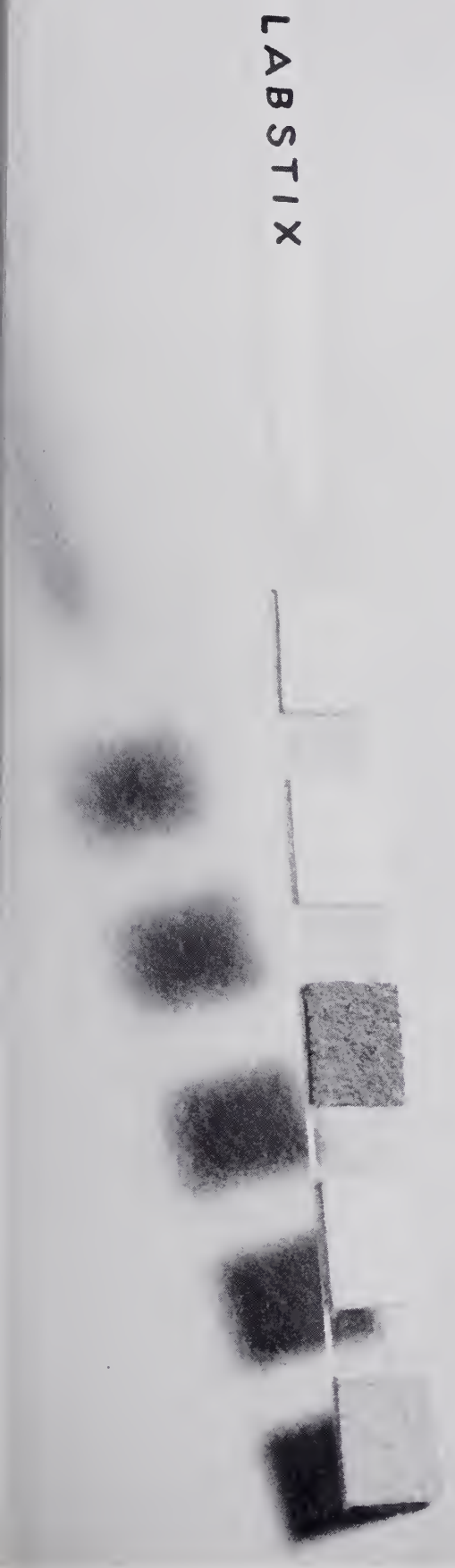
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Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

Dosage: **Oral**—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

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FEBRUARY 1967 • VOLUME 65 • NUMBER 2

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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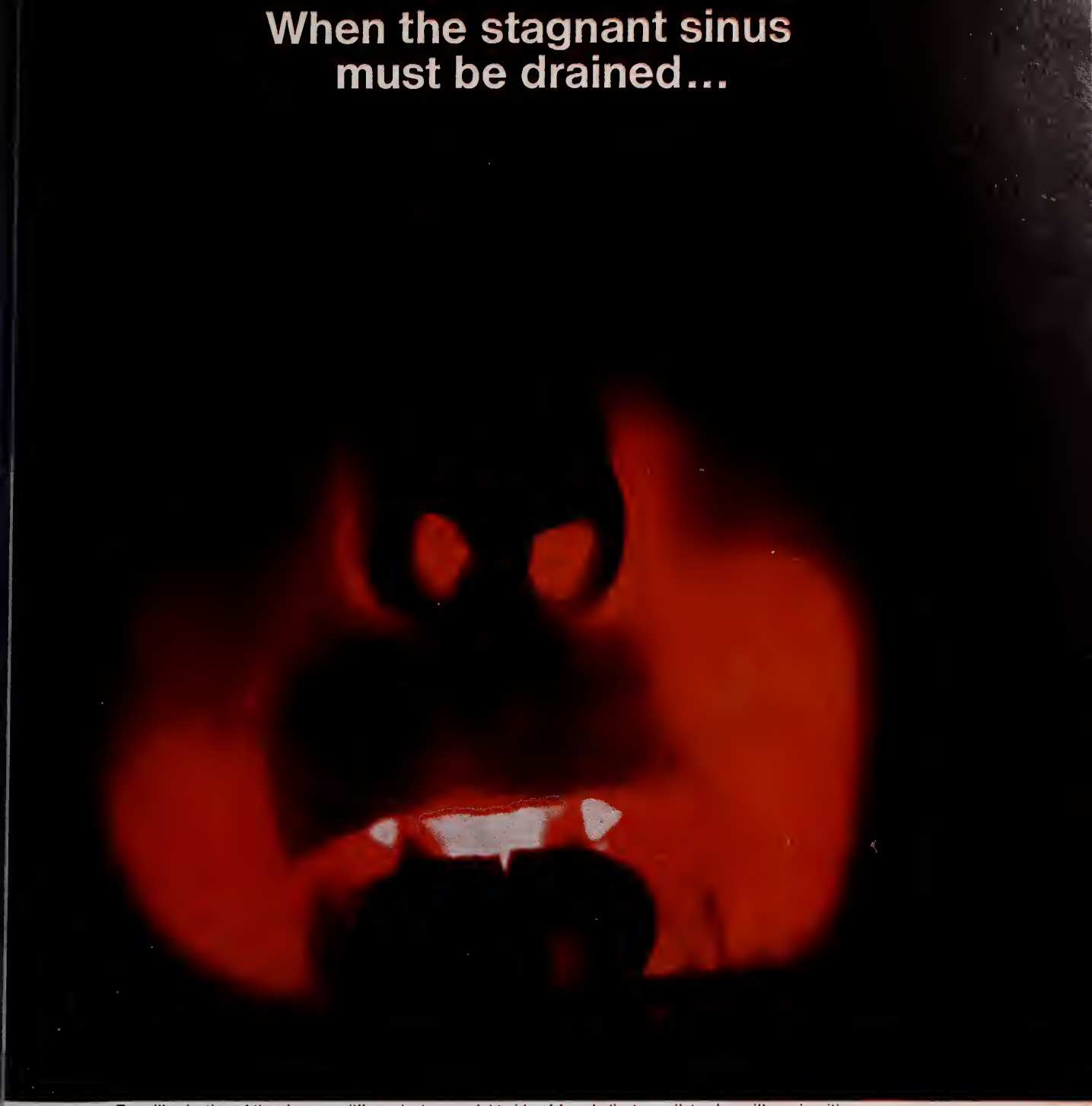
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KMA 1967 Interim Meeting—April 19 and 20

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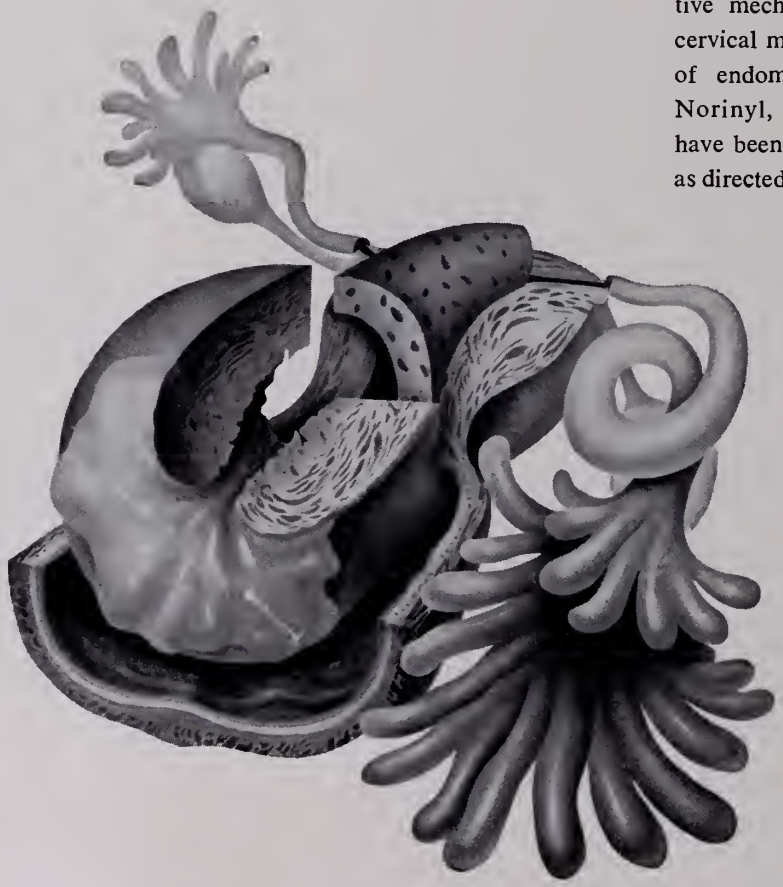
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Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

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Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

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An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, O. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. O.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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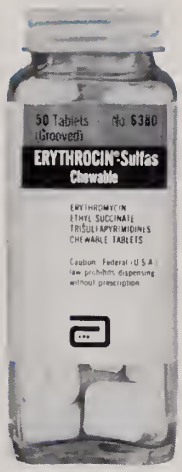
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In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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MESSAGE FROM THE PRESIDENT



MEMBERS of the health profession, at all levels, have been showing increasing concern about the fragmentation of health services. In May, 1966, there were 78 separate grant-in-aid programs available from 13 different federal agencies.

The 89th Congress passed 16 major bills directly affecting health in the nation. Agencies unrelated administratively to health departments are carrying out many of the bill provisions. Many of these programs are overlapping and without a coordinated plan at either national, state, regional, or local levels.

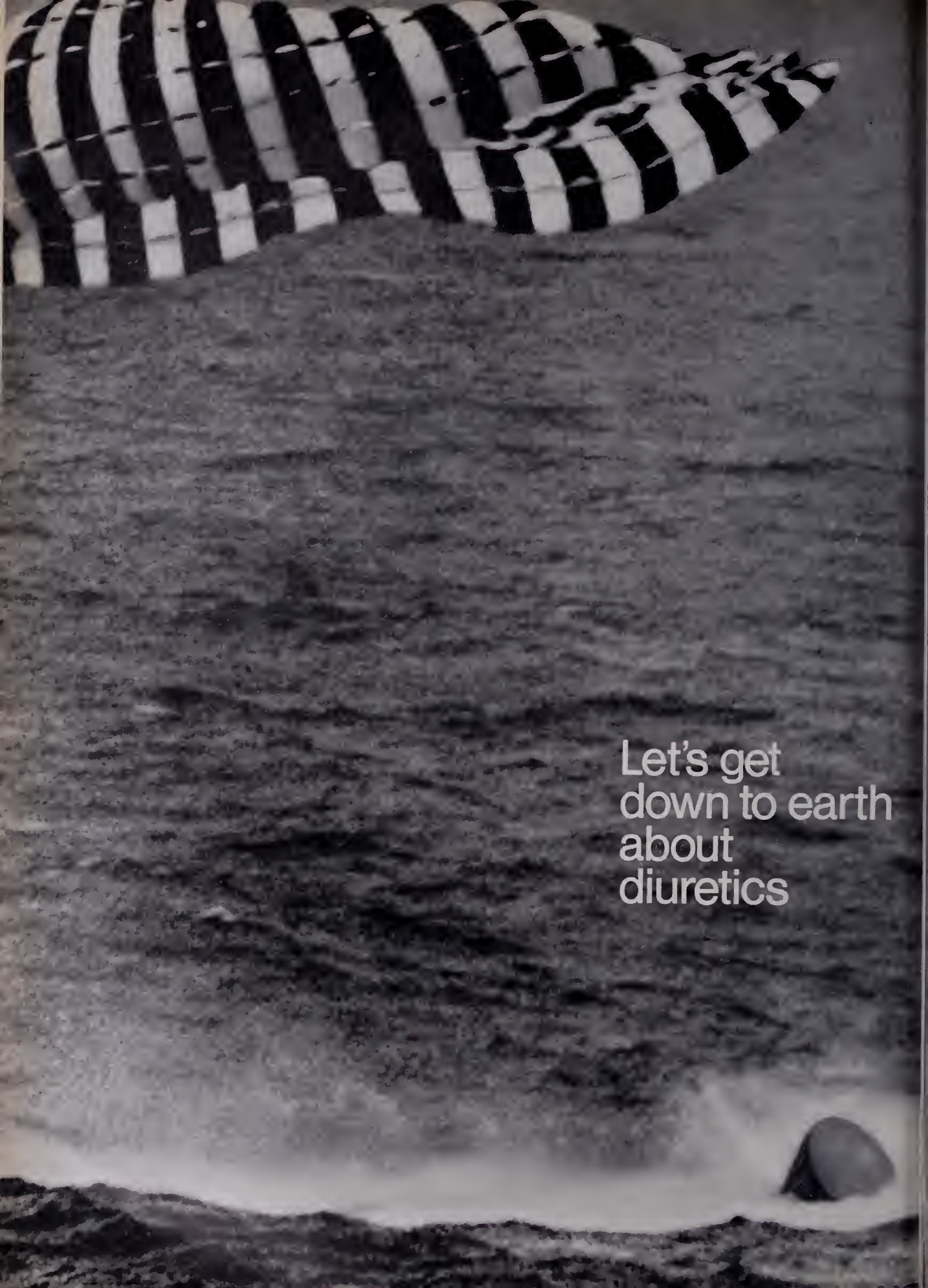
We can no longer afford the luxury of uncoordinated effort. It is too expensive in terms of money and personnel and it does not provide for an adequate quality of health care. Collaboration between the various health resources both public and private are essential to achieve this latter objective.

PL-89-749 allows states to receive federal grants to study health services in the respective states for the purpose of coordinating the various health programs. Some of our state officials feel that such a study should be initiated from the medical profession.

As a result, the Board of Trustees has appointed an ad hoc committee to study Health Services in Kentucky. This committee has had several meetings, a report of which is made elsewhere in this issue of the Journal. It is recommended you give the report thorough study and forward to its Chairman any constructive recommendations which you might have.

(See Page 163)

Robert E. Pennington


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Since the discovery of chlorothiazide, the trend has been away from short-acting, multiple-dose, high-cost diuretics. With Hygroton you can usually do the job with just one tablet a day, or every other day.

More than any of the newer diuretics, Hygroton brings dosage and cost of medication down to earth.

*Brest, A. N., et al.:J. New Drugs 5:329, 1965.

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Indications: Hypertension and many types of edema involving retention of salt and water. **Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease. **Warning:** With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind. **Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. **Side Effects:** Dizziness, weakness, nausea, vomiting, hyperglycemia, hyperuricemia, headache, muscle cramps, postural hypotension, constipation, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin reactions, including urticaria and purpura, epigastric pain, or G.I. symptoms after prolonged administration. **Average Dosage:** One tablet (100 mg.) with breakfast daily or every other day. **Availability:** Tablets of 100 mg. in bottles of 100 and 1000. For full details, see the complete prescribing information. 6524-V(B)

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Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.



J. B. ROERIG DIVISION
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STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY: by Harold F. Schuknecht, M.D., Werner D. Chasin, M.D., and John M. Kurjian, M.D.; Published by the C. V. Mosby Company, St. Louis and London, 1966; 92 Pages; Price, $26.50.

The title of this book is somewhat misleading, as it is not a comprehensive coverage of mastoidotympanoplastic surgery. It rather brings together three distinct points. The first is a brief discussion of the surgical implications of mastoidotympanoplastic surgery and the histopathology of chronic otitis media and mastoiditis. The second and most exhaustive portion could represent a monograph on the specific procedure which the author has adopted as the treatment for a particular problem. The third and concluding portion is a method for teaching temporal bone surgery to the resident staff.

The portion on histopathology superficially discusses the more important aspects of the problems and complications of this disease. The photo micrographs are excellent and demonstrate the various features being discussed.

The technique presented in the second portion is the use of a Type IV tympanoplasty, in association with obliteration of the mastoid cavity, followed by either primary skin grafting or delayed skin grafting. The procedure is extremely well detailed. The accompanying stereoscopic views completely demonstrate the procedure.

Statistical analysis of 116 patients operated with this technique is presented.

I feel that this book represents an excellent presentation of the procedure being described (second portion). It, however, presents little additional information.

GERALD D. LANDAU, M.D.

A MANUAL OF TROPICAL MEDICINE, Fourth Edition: by G. W. Hunter, Ph.D.; W. W. Frye, Ph.D., M.D.; J. C. Swartzwelder, Ph.D.; Published by W. B. Saunders Company, Philadelphia, 1966; 931 Pages; Price $18.50.

The revised, improved edition of this book has a formidable list of qualified contributors. It has a distinct Louisiana-Florida flavor due to the number of authors and contributors from this area.

The book is structured as a manual and it is not a detailed textbook. Most of the epidemiological diagrams have not been changed from the last edition, but current charts and new pictures have been added except for several diseases.

In a broad division by topics the first one-third of the book deals with infectious diseases, beginning with a most challenging section on virology. The middle third deals with a predominant field in tropical medicine, parasitology, and the remaining third presents sections on nutrition, entomology and laboratory procedures.

For a critical examination this reviewer felt the authors missed a real point of emphasis in failing to state that infectious hepatitis is the most common affliction of the foreigner living or visiting in the tropics. It is of greater potential danger than malaria at the present time. Also the Section on Diarrheal Diseases was far too brief. The space taken for the chart of serotypes found in the United States and the culturing procedures for salmonella and shigella could better be used to challenge men to more investigation of etiologies in the tropics. For one with an inquisitive mind, the new treatise on Kuru was of interest—but who would ever see this disease?

This manual should be of great usefulness primarily to those practicing in a tropical or subtropical climate and to teachers of parasitology and tropical medicine. For the physician newly drafted into the armed services, or the stateside practicing physician, it will be useful as a reference book in a library for their immediate referral when faced with a tropical disease.

Finally, each chapter has adequate references for more extensive study. The appendix is a very handy tool for the physician to locate the geographic location of these conditions.

G. DUDY NELSON, M.D., M.P.H. & T.M.

CONTROVERSY IN CULTURAL MEDICINE: by Franz J. Ingelfinger, M.D.; Arnold S. Relman, M.D. and Maxwell Finland, M.D.; Published by W. G. Saunders Company, Philadelphia and London, 1966; 679 pages; price $14.50.

The more carefully the thoughtful clinician examines the bases for his actions, the more he appreciates the dubious bases upon which so many are founded. Still, in everyday practice, he must repeatedly select the wisest course of action for his patient in the face of the sometimes impassioned controversies among authorities. The development of a constructive critical sense is the mark of every mature clinician who wishes to act from more than mere intuition.

This book edited by Ingelfinger, Relman and Finland is a refreshing innovation in the usually stodgy field of medical bookmanship. Opposing points of view on 23 topics of general medical interest are presented by well-chosen authorities, covering such recurrent controversies as the control of diabetes, the anticoagulant dilemma, diet and atherosclerosis, dietary treatment of duodenal ulcer, the best management of rectal polyps, the treatment of rheumatoid

(Continued on Page 197)

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. diabetic patients



2. nonpregnant women with a history of recent or recurrent monilial vaginitis



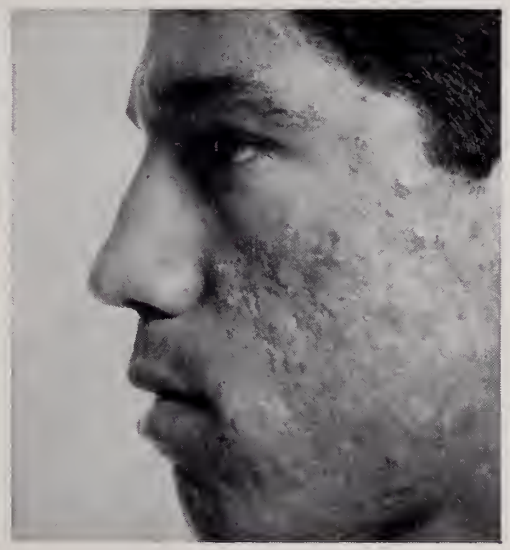
3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



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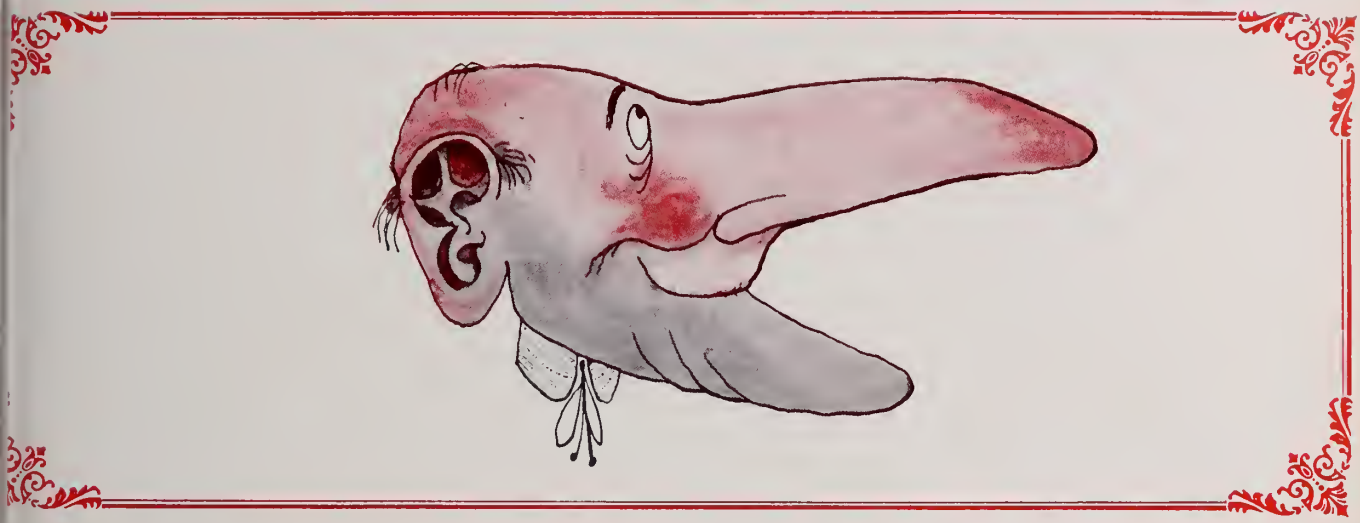
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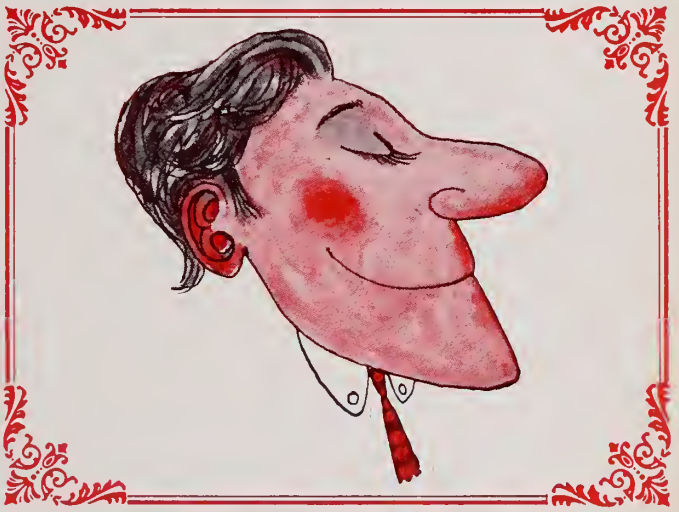
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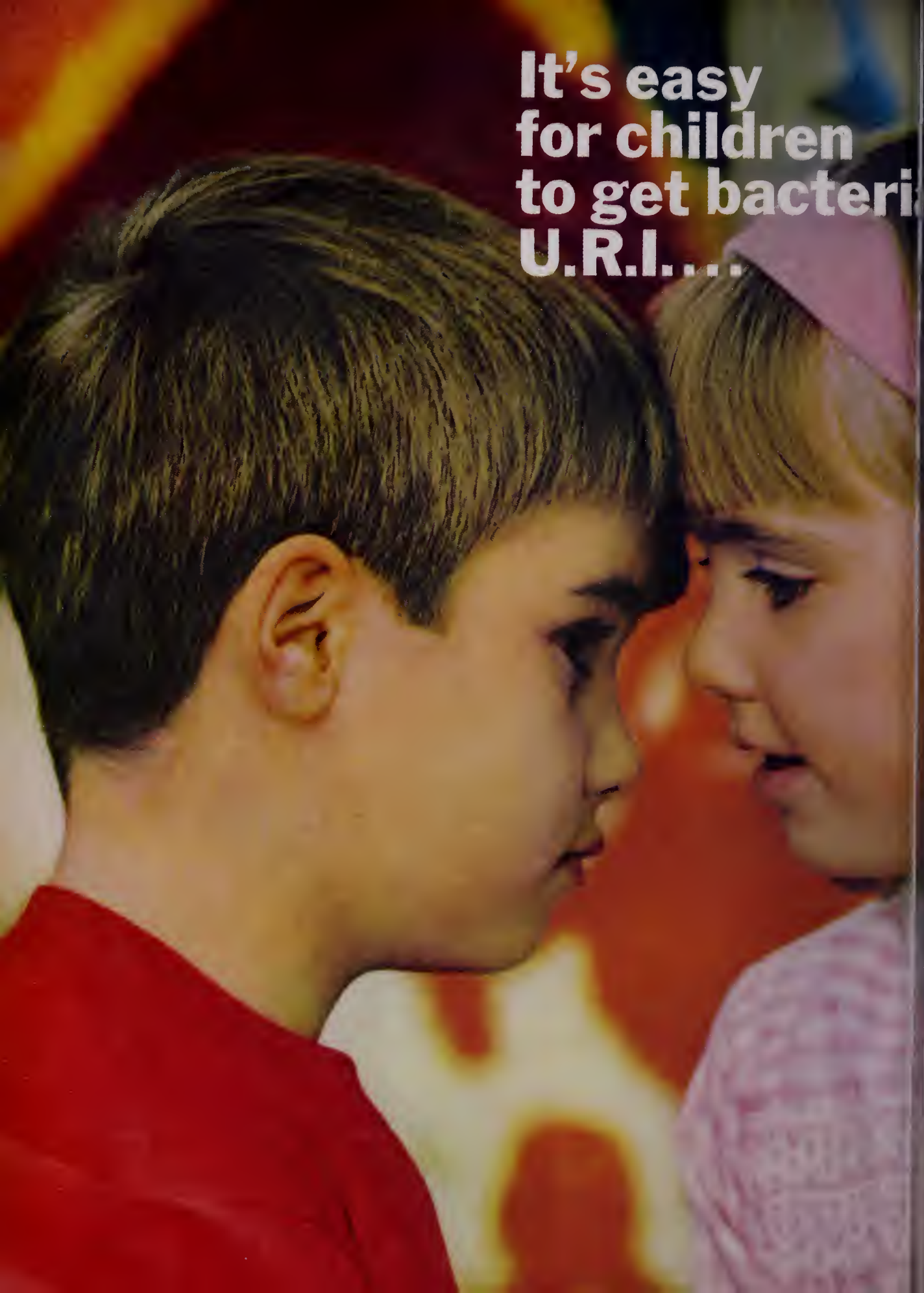
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Precautions: Observe usual sulfonamide therapy precautions, including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus or rickettsial infections.

Adverse Reactions: Following may occur: headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Dosage: Children—1 teasp./20 lbs initially, followed by ½ teasp./20 lbs b.i.d. *Adults*—4 teasp. initially, followed by 2 teasp. b.i.d. or t.i.d., depending upon severity of infection.

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References: 1. Braden, B., and Colmore, J. P.: *J. Oklahoma M.A., 57*:7, 1964. 2. Alban, J.: *Am. J. Dis. Child., 109*:304, 1965. 3. Reichelderfer, T. E.: *Clin. Med., 71*:1045, 1964. 4. Jackson, H.; Cooper, J.; Mellinger, W. J., and Olsen, A. R.: *Southwestern Med., 44*:246, 1963. 5. Braden, B.; Colmore, J. P., and Cummings, M. M.: Antimicrobial Agents Annual—1960, p. 54. 6. Peters, J. H.: Data adapted from a Scientific Exhibit presented at the Spring Meeting of the American Academy of Pediatrics, April 26-29, 1965. 7. Peters, J. H.: Antimicrobial Agents and Chemotherapy—1961, p. 406. 8. Elia, J. C.: *Eye Ear Nose & Throat Month., 41*:722, 1962. 9. Patton, J. M.: *West. Med., 5*:46, 1964. 10. Chastain, P. J.: *J. Florida M.A., 48*:816, 1962. 11. Grater, W. C.: *Antibiotics & Chemother., 12*:450, 1962. 12. Exline, A. L.: *Colorado GP, 5*:(5),11, 1963.

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this issue: the nose as a shock organ

the nose as a shock organ

by Charles J. Shagoury, M.D., Chelmsford, Massachusetts



"Is it a cold, hay fever, or has he been reprimanded by his boss?" Occasionally, you will ask yourself this question when confronted by a patient with abrupt onset of rhinorrhea, nasal obstruction, and sneezing. Usually the history will elucidate the problem, but examination of the nose will often provide valuable clues to the correct diagnosis.

The nose is a shock organ in a double sense. First, it is in the nose that the confrontation takes place with the surrounding atmosphere. For twenty-four hours a day, the nose must meet the varying challenges of the inspired air, containing perhaps noxious chemicals, dust, dirt, bacteria, viruses, fungi, and industrial pollutants of all kinds, and render it clean, virtually sterile, and fit for the sensitive alveoli of the lungs. Whatever the temperature or humidity of the atmosphere, the nose must transmit it to the lungs at approximately 98°F, and with a humidity of approximately 40%.[1]

Second, in particularly susceptible patients, the nose acts as a shock organ in a manner totally unrelated to its normal function. Persons with hay fever respond to ordinarily harmless materials by extreme nasal congestion, with marked rhinorrhea and violent spasms of sneezing. In some patients, exposure to threatening or disagreeable agents, or situations involving mental conflict may result in a reaction which is exclusively nasal, with swelling of the turbinates, and marked hypersecretion.[2]

Nasal symptoms usually result when the nose seeks to perform its function of getting rid of noxious and dangerous elements in the atmosphere, and prevent their admission to the trachea and lungs. Small particles are removed by the mucous coating which blankets the nasal passages. This mucous blanket contains a bacteriostatic agent, lysozyme, which destroys most air-borne bacteria.[3] The mucinous content renders the surface sticky, causing dusts and small particles to adhere. It has been postulated that this process is rendered more effective through adsorption because of a surface electrical charge on the nasal mucosa.[4] The cilia then sweep the particulate matter to the pharynx. The nose can prevent entrance into the lungs of particles as small as three microns in diameter, but smaller particles elude the nasal barrier. Most bacteria causing respiratory infections are one to three microns in diameter, but since they usually are inhaled in clumps, they are efficiently removed as a rule. Viruses, which are of the order of 1/1000 of this size, are less efficiently dealt with, unless they occur in very large aggregates.[5]

The nose will react in a more or less similar manner, whatever the nature of the offending agent, whether it be an irritant chemical, virus, pollen, or distasteful emotional situation. In acute coryza, the most characteristic sign is a profuse watery discharge. The volume of secretion may rise from practically nothing to nearly 60cc in twenty-four hours.[6] The mucous membrane is reddened and engorged, while the turbinates are markedly swollen. After the first day or two, the secretion becomes thicker, yellowish, and more difficult to expel. The surface cells are largely destroyed, contributing to the copious discharge, which now also contains numerous inflammatory cells which have migrated to the area. Gradually, over a period of a few days, or a week, the flood abates, the swelling and redness subside, and the nasal epithelium resumes a healthy appearance.

Repeated attacks of rhinitis, particularly if there is an underlying element of obstruction, may result in chronic rhinitis. The mucous membrane is constantly swollen and reddened. Sticky, mucopurulent secretions are a continuous feature, and the glandular elements are hypertrophied. Commonly, the mucosal surface takes on an irregular, rounded "mulberry" appearance, and nasal passages are occluded by the swollen turbinates and redundant mucosa.

While all of us are susceptible to colds, the victim of hay fever, or allergic rhinitis, displays a marked nasal reaction to materials in the air which leave his associates unaffected. In such a patient, the nasal mucosa has become an allergic "shock" organ. Contact with the nasal allergen causes local release of histamine, with vasodilatation, increased vascular permeability, and severe nasal congestion, similar to the "wheal" and "flare" reactions in the skin, when the epidermis is the allergic shock organ. While we eagerly await the coming of spring, the hay fever sufferer dreads the blooming season, whose invisible pollens are poisons to his sensitive nose. His neighbor's cat or dog may provoke paroxysms of uncontrollable sneezing. In some cases a specific allergen is not identified, but the triad of rhinorrhea, nasal obstruction, and sneezing is present.[7] The nose in these cases shows a pale, boggy, edematous mucosa, with a thin mucoid secretion. The mucous membrane shows extreme retractility to 1% cocaine or ephedrine. If the patient has medicated himself prior to examination, the nasal passages may appear abnormally patent, or show exaggerated congestion due to rebound reaction. The secretion may show a large number of eosinophils particularly after an attack of sneezing or rhinorrhea. Touching the mucosal surface, especially of the inferior turbinate, leaves an indentation, showing that the swelling is due to stasis and edema, rather than actual hyperplasia of the mucous membrane as in chronic hypertrophic rhinitis. Though the pale swollen mucosa is the hallmark of allergic rhinitis, as usually seen by the physician, exposure of allergic subjects to their known allergens results in a brief hyperemic phase, followed by pallor and edema.[8]

In the later stages of allergic rhinitis, the chronic edema of the mucous membrane results in the formation of polyps, clusters of grape-like masses hanging from the roof of the nose, with a pale glistening surface, contributing significantly to the sense of nasal obstruction and oppression.

A large group of patients show symptoms of nasal congestion when confronted by adverse life situations.[9] In these unfortunate persons, anxiety, frustration, and resentment are often accompanied by a runny nose and nasal obstruction. Lacrimation adds to the nasal stuffiness. This autonomic response, mediated by the parasympathetic nervous system, may be part of a general parasympathetic reaction, or may possibly represent in part, a symbolic effort to wash out and crowd out the offending situation.

Nasal congestion may also occur in some patients at times of sexual stimulation, and in women during menstruation and pregnancy, even to the point of epistaxis.[10] The relationship is obscure; castration results in atrophy of the nasal glands, and their action is inhibited by the hormones of the hypophysis and the thyroid.[11] The nose may be the shock organ in drug therapy. The nose may also bear the brunt of industrial stress, in those who work in a hot dry atmosphere, or those exposed to acid fumes, or irritating dusts. As the air in our cities is increasingly polluted by exhaust fumes, and industrial irritants, whole urban populations may suffer from chronic nasal and respiratory symptoms.

Of course, nasal reactions are not just infectious, or allergic, or emotional. Particularly in the chronic sufferers, there is an interdependence of all three. Death of a relative, or other psychic shock can pre-

(concluded on following page)

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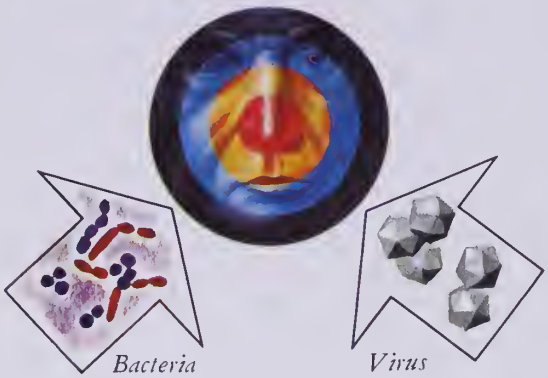
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cipitate an attack of rhinorrhea in hay fever sufferers.[12] Others develop attacks of vasomotor rhinitis following change in temperature, chilling, or exposure to the sun, or simply warm bedclothes.

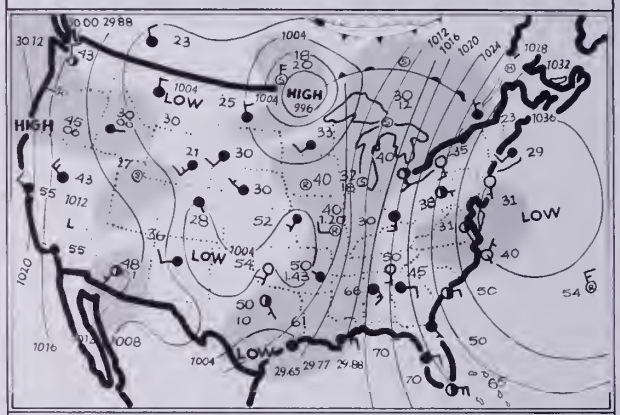


The complex interplay of allergy and infection is largely unclear. Allergy to the viruses and bacteria which cause infection has been postulated, but is difficult to demonstrate. The swollen obstructed allergic nose is more susceptible to infection. At the same time, infection often precedes or precipitates an allergic attack. Exposure of a susceptible patient to an allergen can activate latent virus organisms leading to infection.[13] This "jolt" reaction represents a summation of an allergen and a virus leading to symptoms in the nose as a shock organ, which neither could have produced alone. In childhood, repeated attacks of bronchitis and colds may be inflammatory reactions to an allergen, or precipitated by exposure to an allergen. These children may later develop typical allergic rhinitis. On the other hand, children with typical allergic histories, eczema, asthma, and allergic familial backgrounds, may later develop typical infectious rhinopathies. Skin tests in such patients are usually positive.

Nasal reactions are part of the systemic response of the patient to an unwelcome stimulus. In cases of respiratory infection and exposure to atmospheric irritants, the reactions are useful, and to some extent desirable. They are usually self-limited, disappearing within a few days, or upon removal of the provoking agent. Here the distressing symptoms can be ameliorated with appropriate decongestant agents, or, in the case of severe or complicated respiratory infections, antibiotics may be given, with reasonable confidence of a cure. On the other hand, when nasal reactions are the peculiar response of an individual to an allergen, or to an undesirable situation, they serve no useful purpose. The nose here is a shock organ in a stressful situation, but can furnish no response of value. It merely causes the patient symptoms which add to his problems. In these cases, symptomatic treatment is of great benefit, but often the underlying faulty pattern of response cannot be altered. Such a patient may literally be considered to be paying his way in life "through the nose."

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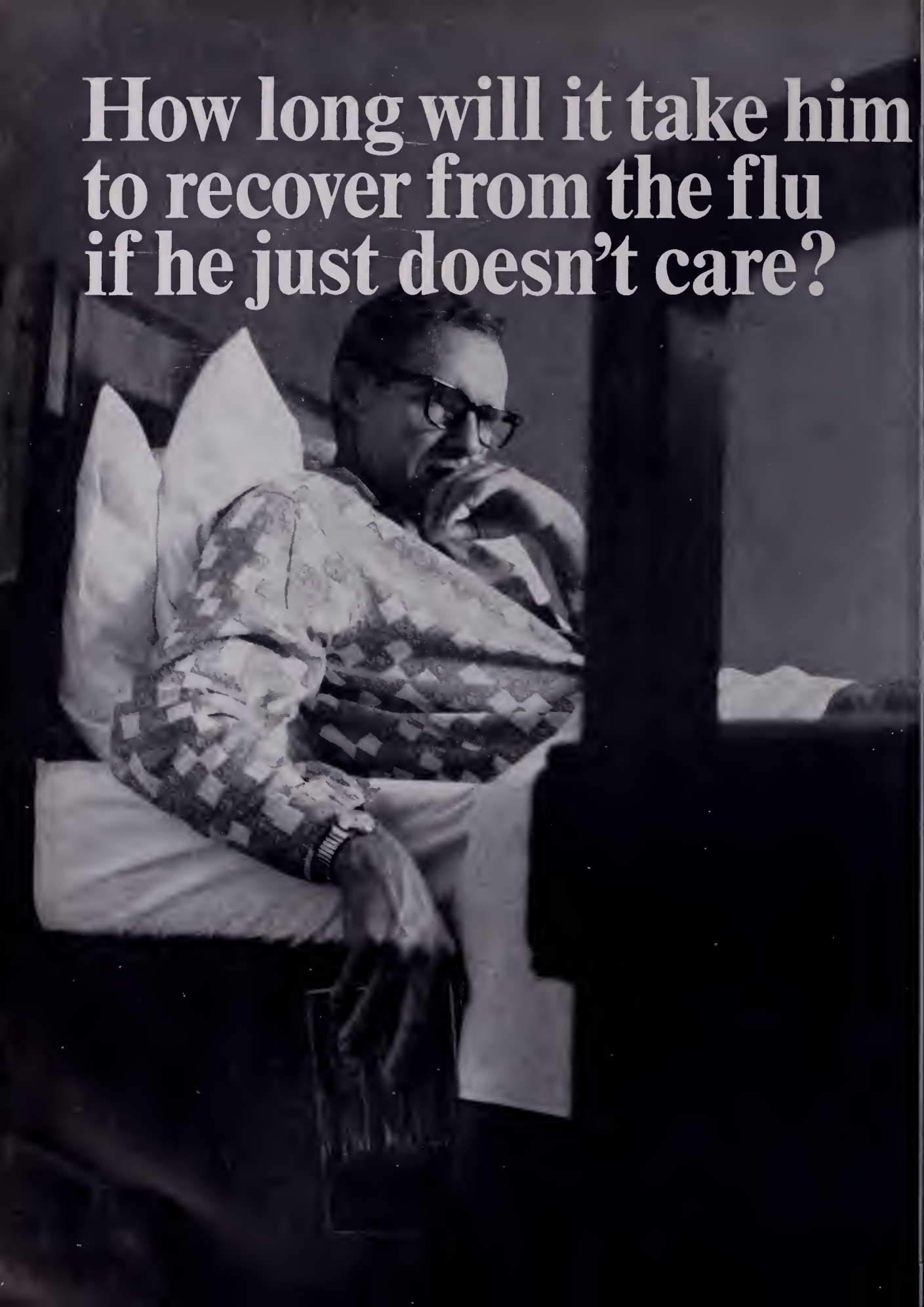
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Recent Advances In Treatment Of Myasthenia Gravis †

J. E. Tether, M.D., F.A.C.P.*

Indianapolis, Indiana

In the past thirty years, mortality in myasthenia gravis has been reduced from more than 90% to less than 10% by improved treatment and better management of crises.

MYASTHENIA gravis is a variable condition of fatigability and weakness of voluntary muscles. Although extraocular muscles are frequently affected, any muscle group may be involved.

The current concept of etiology is that, at least in some cases, an auto-immune globulin blocks the action of acetylcholine (ACh) at the myoneural junction. ACh may be elevated by anticholinesterase drugs which decrease ACh destruction by cholinesterase, allowing it to rise to a level sufficient to overcome the block.

The purpose of this paper is to present briefly the advances in therapy of myasthenia gravis that have been made in the last thirty years. The reader is referred to other sources[1,2] for more detailed information regarding management.

Anticholinesterase Drugs in Current Use

Prior to 1935, when the dramatic effect of neostigmine (PROSTIGMIN) on patients with myasthenia gravis was first demonstrated[3], over 90% died in myasthenic crises. The remainder were fortunate enough to survive due to natural remissions. Today the same number have remissions, but less than 10% die, thanks to adequate treatment, which enables many to return to useful work.

Neostigmine is also an effective diagnostic agent, as only myasthenia gravis responds to its administration[4]. This has resulted in the diagnosis of many thousands of cases of this "very rare" disease. (Figure 1).

I have also described a condition I first called the "mild myasthenic state"[5]. Because of the confusion with myasthenia gravis, I have since renamed it the "myasthenoid fatigue syndrome". While too mild to be termed "gravis", fatigability with visual disturbances and pain in the back, neck, and legs respond subjectively and objectively to anticholinesterase drugs. In my experience, this condition

†*Presented at KMA's Annual Meeting in Louisville, September 21, 1966.*

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is probably far more prevalent than myasthenia gravis.



FIGURE 1: A. Patient E.F., off Prostigmin for 12 hours. B. Patient E.F., Immediately after Prostigmin 0.5 mg. intravenously.

Neostigmine remained the only effective drug in myasthenia gravis treatment until the last decade when pyridostigmine (MESTINON) was introduced[6,7]. This drug has a slightly more prolonged effect and less gastro-intestinal side-effects than neostigmine. Its effect may be further prolonged by incorporation in a resin base (MESTINON TIMESPAN).[8] Also in the last decade, ambenonium (MYTELASE, Win 8077) was introduced. MYTELASE has a more rapid onset of action, and its effect is somewhat more prolonged. Gastro-intestinal side-effects are less severe than those of Prostigmin or Mestinon.[9,10] Muscle fasciculation, cholinergic weakness, and choking may be the first sign of overdosage with Mytelase. Therefore, this drug should be used with caution, preferably in patients who have had previous experience with Prostigmin or Mestinon.

Edrophonium (TENSILON CHLORIDE), while too brief in action to have therapeutic value, is an excellent drug for diagnostic purposes (Figure 2), or for regulating therapy with other anti-ChE drugs.[2,11] For diagnosis, we first measure the degree of weakness and myasthenic signs. These measurements are repeated after a placebo. Then Tensilon, in a tuberculin syringe, is injected intravenously at the rate of 0.1 cc. or 1 mg. every 30 seconds. In the intervals, the patient is watched closely for eyelid fasciculation, nausea, abdominal cramping, or "tightness" in the throat. Injection is stopped immediately should these symptoms occur. After they cease, which they usually do in a minute or two, the degree of improvement is measured.

In a patient under treatment, it is occasionally difficult to determine whether weakness, or even crisis, is due to overdosage (cholinergic weakness) or underdosage (myasthenic weakness). For this purpose, *no more* than 0.2 cc. (2 mg.) of Tensilon is placed in a tuberculin syringe, and 0.1 cc. is given intravenously. Should no side-effects appear or worsening occur, the other 0.1 cc. is given, but if no improvement occurs at 0.2 cc., the weakness or crisis is assumed to be cholinergic, and the appropriate antidote (vide infra) is given. If improvement occurs, however, the patient is probably underdosed, and his regular anti-ChE dosage is raised.

Application of Anticholinesterase Therapy

Treatment of myasthenia gravis is aimed at improvement in strength and endurance to a level as near normal as possible.

Many myasthenic patients show extreme variability in the dosage requirements. The condition is aggravated by exertion, emotion, infection, menstruation, surgery, injuries, or any kind of stress, and is relieved by rest. Therefore, no rigid dosage schedule is prescribed. Each patient must learn to vary his dosage according to his needs or side-effects from the drug. (Figure 3).

A comparison of potency of the various anticholinesterase drugs in current use is presented in Figure 4. The comparative oral dosage is only a rough approximation because of variability in intestinal absorption.



FIGURE 2: A. Patient R.G., Off Prostigmin for 12 hours. B. Patient R.G., Immediately after Tensilon, 10 mg. intravenously.

At times, the symptoms of cholinergic crisis mimic those of myasthenic crisis, as the usual muscarinic side-effects may not occur. Far more deaths are due to cholinergic than

myasthenic crises. This is often due to an injection of Prostigmin when a patient is already overdosed.

SIDE-EFFECTS OF ANTICHOLINESTERASE DRUGS	
MUSCARINIC	NICOTINIC
Flushing	Weakness ("tight" or "quivery")
Sweating	Muscle fasciculation
Salivation	"Tight" feeling in tongue and throat
Lacrination	Muscular cramping
Nausea	Headache
Vomiting	Miosis
Abdominal cramping	Restlessness
Diarrhea	Confusion
Urgent urination	Increased diplopia
Bradycardia	Vertigo

FIGURE 3

Tensilon[2] may differentiate the two types of crisis, but it is not always infallible. In case of doubt, *atropine sulfate* should be given intramuscularly or intravenously in doses of from 0.6 mg. to 1.2 mg., until a dry mouth or pupillary dilation occurs. Atropine will not increase weakness should the patient be underdosed.

Every patient on anticholinesterase drugs should be supplied with atropine to take by mouth in case of overdosage.

We use 0.4 mg. hypodermic tablets because of their solubility and small size, and advise one or two every 15 minutes, depending on severity of reaction, until relief or dry mouth occurs. Severe or "brittle" myasthenics are also supplied with injectable atropine solution.

In starting newly diagnosed patients on therapy, we use Mestinon because of its milder side-effects. We start with a very low dose and increase slowly in all but the most severe myasthenics. (Figure 5).

As many physicians do not have the time or facilities for intravenous testing, I have recommended the same schedule as an oral therapeutic test in patients suspected of myasthenia gravis, or of the myasthenoid fatigue syndrome.

Experimental Therapy

Because none of the anticholinesterase drugs in current use are free of undesirable side-effects and as none are completely effective in even the most responsive patient, attempts have been made to find drugs with longer action and less side reactions.

The alkyl-phosphates, a class of compounds used as insecticides and possible warfare chemicals inhibit cholinesterase irreversibly. One of these OMPA[13], has an anti-ChE activity lasting several weeks. While this may be advantageous to a patient with a high tolerance and a steady need, it presents a real hazard to most myasthenics whose needs vary considerably. Therefore, it is no longer in use as treatment for myasthenia gravis.

The *BC drugs*, polymethylene-linked double molecules of Prostigmin and Mestinon, have an action lasting about 72 hours. These drugs have an accumulative action similar to OMPA which limits their value in treatment of myasthenia gravis.

COMPARISON OF POTENCY OF CURRENT ANTICHOLINESTERASE DRUGS				
DRUG	DOSAGE FORM	INTRAVENOUS	INTRAMUSCULAR	ORAL
Prostigmin Methylsulate	Ampoules of solution 1:4000 - 0.25 mg cc. 1:2000 - 0.5 mg cc. 1:1000 - 1 mg cc. 10cc. vials.	0.5 mg.	1.5 mg.	—
Prostigmin Bromide	Tablets: 15 mg. single scored	—	—	15.0 mg.
Mestinon Bromide	Tablets: 60 mg. double scored	—	—	60.0 mg.
Mytelase Chloride	Tablets 10 mg. 25 mg. single scored	—	—	5.0 mg.
Mestinon Bromide Timespan	Tablets 180 mg. single scored	—	—	60.0 mg.
Tensilon Chloride	Ampoules of solution 1cc. - 10mg cc. 10cc. vials. - 1 mg. cc.	10.0	20.0	—

FIGURE 4

Echothiophate (PHOSPHOLINE IODIDE)*[14,15] is a hybrid molecule, combining acetylcholine and phosphate esters. It is a highly active anti-ChE drug with a peak effect at about six hours and a sustained effect of about twelve hours. Our clinic has had experience (soon to be published), with seventy patient trials with Phospholine since 1959. (Figure 6). Twenty-one are still on the drug, and all of these are responding to Phospholine better than to any previous therapy. Twenty did well but discontinued the drug due to partial or complete remissions. Twenty-six did not tolerate the drug or were better on their previous therapy. Three patients died in crisis while taking Phospholine.

In our experience, Phospholine, milligram for milligram, is as much as a hundred times

**Ayerst Laboratories, New York, supplied the echothiophate (PHOSPHOLINE IODIDE) for our investigational use.*

as powerful as Prostigmin, Mestinon, or Mytelase.

In general, patients who do well on Phospholine are of the steady, high-tolerance, high-dosage-need type. The "brittle" or unstable patient is unable to manage the drug. Most of our failures were in patients of this type.

Figure 5

TO PATIENTS STARTING MESTINON TREATMENT

IMPORTANT INSTRUCTIONS
PLEASE READ CAREFULLY

MESTINON HAS ONLY ONE ACTION. IT RAISES THE LEVEL OF ACETYLCHOLINE WHICH NORMALLY STIMULATES YOUR MUSCLES, SALIVA, NASAL, TEAR AND SWEAT GLANDS, STOMACH, BOWEL, AND BLADDER. IT IS ABSORBED TOO FAST ON AN EMPTY STOMACH SO UNLESS YOU HAVE SEVERE MYASTHENIA, IT SHOULD ALWAYS BE TAKEN WITH OR IMMEDIATELY AFTER MEALS. THE RIGHT DOSE SHOULD GIVE IMPROVEMENT IN STRENGTH AND ENDURANCE WITHOUT ANY SIDE-EFFECTS. IT SHOULD LAST UNTIL YOUR NEXT DOSE. IF IT DOES NOT, YOU ARE PROBABLY UNDERDOSED. IF YOU HAVE REACTIONS BEFORE IMPROVEMENT, OR IF, YOU HAVE NO IMPROVEMENT ON 2 TABLETS AFTER MEALS, YOU PROBABLY DO NOT HAVE ANY DEGREE OF MYASTHENIA.

START WITH 1/4 TABLET 3 TIMES DAILY, ALWAYS AFTER MEALS, FOR 2 FULL DAYS. IF NO REACTIONS OCCUR, RAISE BY 1/4 AFTER MEALS, 3 TIMES DAILY, EVERY 2 DAYS UNTIL A SLIGHT REACTION OCCURS OR YOU REACH 2 TABLETS, 3 TIMES DAILY.

REACTIONS

1. MUSCLE TWITCHING
2. EXCESS SALIVA, TEARS, OR NASAL SECRETIONS
3. SWEATING OR FLUSHING
4. DIZZINESS
5. UNUSUAL BLURRING OF VISION
6. TINY PUPILS IN YOUR EYES
7. "THICK TONGUE"
8. "CHOKY" FEELING
9. NAUSEA
10. STOMACH CRAMPS
11. DIARRHEA
12. URGENT URINATION
13. UNUSUAL "QUIVERY" OR "TIGHT" WEAKNESS

IF ANY OF THOSE IN LEFT COLUMN APPEAR, TAKE 1 ANTIDOTE TABLET, OR 2 IF ANY IN RIGHT COLUMN. REPEAT DOSE EVERY 15 MINUTES UNTIL REACTIONS LEAVE OR A DRY MOUTH OCCURS.

TAKE NO MORE TABLETS ON DAY OF REACTION, BUT NEXT DAY CUT THE DOSE BY 1/2 TABLET. IF REACTION HAS BEEN SEVERE, CUT DOSE IN HALF.

EVEN IF NO DEFINITE REACTION OCCURS, BUT IF YOU FEEL WEAKER AS YOU RAISE THE DOSE, CUT BACK TO WHERE YOU FELT BEST.

ABOUT ONE IN FIVE PATIENTS HAVE REACTIONS FROM THIS MEDICATION WHEN THEY TAKE ASPIRIN. IF YOU MUST TAKE IT, OMIT ONE DOSE AND TAKE AN ANTIDOTE TABLET WITH THE ASPIRIN.

AVOID ENEMAS OR STRONG LAXATIVES. TAKE NO MORPHINE OR QUININE. ALCOHOL CAUSES REACTIONS IN SOME PATIENTS WHEN TAKEN WITH THIS MEDICINE. IN OTHERS, IT HAS NO EFFECT.

MOST ANTIBIOTICS, ANTIHISTAMINES, LOCAL ANESTHETICS, TRANQUILIZERS, AND MILD SEDATIVES ARE USUALLY WELL TOLERATED WITH THIS MEDICATION.

FIGURE 5

With only three exceptions, we hospitalized all patients for transfer to Phospholine. As there may be synergism between Phospholine and both Prostigmin and Mytelase, we have first transferred all patients to Mestinon. We start Phospholine with 0.5 mg. b.i.d., gradually reducing Mestinon and increasing Phospholine by 0.5 mg. b.i.d. until optimum response or side-effects occur. Side-effects are antidoted and the next dose or two are omitted. Then we resume with half as much.

Because of the extreme potency of Phospholine, it is, and should be, limited to use in myasthenia gravis treatment centers under careful supervision.

Thymectomy

Thymic tumors and hyperplasia have been found in some patients with myasthenia gravis, and these patients are usually of the "brittle" type. It is known that surgical removal of an actual thymoma may aggravate symptoms or may even precipitate myasthenia gravis in a previously non-myasthenic patient.

In several clinics, surgical removal or hyperplastic thymuses or thymic remnants has been reported to bring about a higher remission rate, especially in young females. In other clinics, as well as our own, medically treated cases seem to do as well or better than thymectomized patients. Only time will tell whether or not thymectomy is indicated for treatment of myasthenia gravis.

X-Ray Therapy

We have used x-ray therapy in severely ill myasthenics with thymomas, as thymomas are usually highly radiosensitive. The aggravation of symptoms after this therapy seems less pronounced than after surgical thymectomy.

PHOSPHOLINE THERAPY IN MYASTHENIA GRAVIS 70 PATIENT TRIALS 1959-1966	
Still on Phospholine with good results	21
Discontinued due to partial or complete remission	20
Discontinued due to intolerance	26
Died in crisis while on Phospholine	3

FIGURE 6

ACTH Therapy

Since ACTH causes shrinkage of lymphoid tissue[16], Torda and Wolff[17] tried this hormone in myasthenics in an effort to shrink thymic tissue and therefore induce remission. They reported worsening during therapy, but partial remission when ACTH was discontinued. However, other investigators subsequently reported crisis during ACTH therapy, and for some time this treatment was considered too dangerous.

Improvement of therapy for myasthenic cri-

sis, with positive pressure respirators in intensive care units has lessened the danger of ACTH therapy, and it has therefore been revived. Many courses of treatment have been reported by several investigators in the past few years[18,19]. Improvement varied from partial to complete remissions for several months. When relapses occurred, improvement was again obtained by another course of ACTH. Relapse may be prevented by small doses (20 to 40 units) weekly to monthly[19].

One of our cases illustrates the improvement possible in a previously "brittle" severe myasthenic:

A. B., a 40 year old white man, was admitted to Long Hospital intensive care unit on 7-20-66 for a trial of ACTH therapy.

The onset of myasthenia gravis was in 1960, with eyelid ptosis and diplopia, rapidly followed by general weakness, dysarthria, dysphagia, and dyspnea. Only fair to poor regulation was accomplished on every anti-ChE medication in current use including Phospholine.

In February 1965, he suffered an extremely severe myasthenic crisis. A tracheostomy was done and had been left in place because of several subsequent crises.

On admission he was on four 15 mg. tablets of Prostigmin every 3 hours and 1½ Mestinon Timespan tablets h.s. He had complete eyelid ptosis requiring lid crutches, a total absence of extraocular movements, severe dysarthria, dysphagia with gradual weight loss, and severe general muscle weakness. He was unable to chew, or even to close his mouth.

Laboratory studies, including C.B.C., urinalysis, BUN, electrolytes, CO_2, P.B.I., fasting and 2 hours post-prandial blood sugars, were all within normal limits. PA and lateral chest films were normal. An electromyogram showed the classic myasthenic pattern. He was past his dosage time when this was done, and he developed severe dyspnea and cyanosis, which was quickly relieved by i.p.p. respirator and aspiration. Ergograms showed extreme weakness and fatigability.

He was started on ACTH on 7-22-66 with 100 mg. daily, or 25 mg. every six hours, intramuscularly. On 7-24-66, all of his myasthenic symptoms and signs were worse, but all showed a better response to intravenous Tensilon than he had had for several years. His Prostigmin dose was raised to 5 tablets (75 mg.) every 3 hours.

On 7/28/66, his condition again worsened, but he responded even better to Tensilon, with 3 mm. palpebral fissures, improved speech, swallowing, tongue protrusion, neck and jaw strength, and ergograms. By this time his Prostigmin dosage was up to 90 mg. (6 tablets) every 2 hours. This was his highest dosage.

On 8/1/66, 3 days after ACTH was discontinued, he had almost no eyelid ptosis. There was great improvement in his dysarthria, appetite, and dysphagia. Electromyograms showed almost no "fall off" on nerve stimulation. There was no marked change in any of his laboratory studies. His blood pressure remained stable throughout, and he never again needed a respirator.

He was found to be overdosed on Prostigmin, and his dosage rapidly declined to 2 tablets, (30 mgs.), every 2 hours during the day and 1 tablet (15 mg.), at night.

He was discharged, greatly improved, on 8/6/66. In the past month he has received 100 mg. of ACTH intramuscularly once a week, and his improvement has been maintained on the same dose of Prostigmin.

ACTH should always be given in an intensive care unit. It should not be given to any patient having a condition contraindicating its use, unless the severity of the myasthenia is considered a greater danger to life than that condition.

Protopam

Although atropine is effective in combating the muscarinic side-effects of overdosage of anti-ChE drugs, it has less effect on the nicotinic side-reactions.

An oxime, 2-pyridine aldoxime methochloride (PROTOPAM)* has been found useful in cholinergic crisis.[20] It will reserve the action of most anti-ChE compounds, especially Phospholine, on the neuromuscular system. Apparently it does this by regenerating cholinesterase.

Atropine should also be used in cholinergic crisis, as Protopam has little effect on muscarinic side-effects.

Tensilon should always be available should Protopam aggravate the crisis, in which case it would be myasthenic rather than cholinergic.

Protopam is available as a powder in one-

**Available on an experimental basis from Ayerst Laboratories, Medical Department, 685 Third Avenue, New York, N.Y. 10017.*

gram ampules. It is dissolved in 20 cc. of sterile water. We give 1 cc. intravenously every 30 seconds, until maximum improvement or aggravation occurs. If the latter occurs, it may be reversed by Tensilon.

Protopam has also been made available in tablet form for experimental use. We have found it effective against milder cholinergic symptoms due to overdosage with all anti-ChE drugs in current use.

Summary

A brief account is presented of advances in therapy of myasthenia gravis since the first effective drug was discovered in 1935. As myasthenia gravis is no longer considered a rare disease, this information may be useful, if only to stimulate interest in its diagnosis and treatment. However, the reader is urged to consult the bibliography for more detailed discussions of its management.

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Treatment of Pain Related to Cancer†

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The patient with cancer pain becomes a candidate for pain surgery when medication requirements exceed codeine by mouth. This paper discusses the various surgical procedures and their application to specific pain problems.

PAIN, originating from the Latin *poena* meaning penalty, initiates reflex and voluntary protective mechanisms. Under certain circumstances pain serves no useful purpose, and to the sufferer chronic pain becomes a symbol of rejection.[2] The suffering imposed by pain is a highly personal matter, difficult to define and impossible to describe in objective terms. Because individuals differ widely in their response to pain,[21] discomfort which incapacitates one person may be borne with equanimity by another. Clinical measurements of pain can establish pain thresholds which prove to be conditioned by numerous factors, including previous experience with pain and the individual's interpretation of its significance.[12]

The concept of two distinct types of pain has evolved to separate the quick, sharp pain and the slower dull aching pain which follow an appropriate stimulus.[6] Epicritic (fast) pain is conducted by alpha fibers at a speed of 15-20 meters per second, and protopathic (slow) pain is conducted by C fibers at a rate of two meters per second. Activation of epicritic alpha fibers produces intense, sharply localied pain of brief duration. Conversely, activation of smaller C fibers leads to prolonged diffuse discomfort having a strong affective quality. The pain suffered by patients with cancer conforms to the characteristics of C fiber (protopathic) pain.[13]

Efforts to relieve pain may be directed against the primary cause when the cause can be treated by specific measures. Pain due to cancer often cannot be treated satisfactorily at its source and instead attempts are made either to interrupt pain pathways or to modify the patient's response to pain at the highest levels of neural activity. Measures taken to relieve pain due to cancer should take into consideration the ultimately fatal nature of the disease and the limited period for which relief must be provided.

Surgical Relief of Pain

Posterior sensory rhizotomy was introduced in 1889 by Bennett in England[3] and by Abbe in the United States.[1] Bennett's patient had syphilitic osteitis of the left tibia and after various procedures, including amputation at the knee, had proven ineffective, Bennett relieved the pain by sectioning lumber and sacral posterior roots on the painful side. Abbe divided cervical postcrior roots to relieve the pain of a patient with neuralgia of the brachial plexus. The first cordotomy on man was performed in 1911 by Martin at the suggestion of Spiller.[23] Martin, a professor of surgery at the University of Pennsylvania, relieved the pain caused by a tumor of the cauda equina by dividing the anterolateral columns bilaterally. Egas Moniz received a Nobel Prize in 1949 for his work on prefrontal leukotomy in the treatment of psychiatric disorders[19] and the

†*Supported in part by the Dewey Daniel Fund, the Fred Rankin Fund for Surgical Research, and the American Cancer Society, Kentucky Division.*

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procedure was later adopted for the treatment of pain. Despite a subsequent rise and fall of enthusiasm operations directed at the frontal lobe and its connections have maintained a place in the treatment of chronic pain.

The surgeon must consider not only the anatomical region involved by pain, but also the cause of pain at its source. Turnbull[25] in a careful study of 100 patients defined six painful syndromes produced by carcinoma of the cervix — hydronephrosis, iliac thrombophlebitis, recurrent cervical erosion, rectal reaction due to radiation, bone metastases, and lumbosacral plexus involvement — of which only two, bone metastases and lumbo-sacral plexus involvement, are treated best by interruption of pain pathways. In evaluating pain in the patient known to have cancer, the surgeon assumes responsibility for selecting the most appropriate course of action, whether surgical or non-surgical, for the individual patient taking into consideration the suspected or known cause of the pain, its anatomical site, and the patient's psychic constitution.

Surgery is indicated in the management of pain when the cause defies more direct treatment and when severity of the pain justifies a major operative procedure.[20] Patients with a life expectancy shorter than two months should rarely be subjected to a neurosurgical pain-relieving operation.[26] With allowance for occasional exceptions, prediction of life expectancy proves surprisingly accurate as shown by an earlier study.[14] Although not an absolute contradiction to surgery, established narcotic addiction complicates surgical management and lessens chances of obtaining an excellent result. Experience has shown that surgery should be considered when a patient requires more than codeine by mouth, or its equivalent, for pain relief. Emotional instability, more often a life pattern than the response to fatal illness, constitutes a relative contraindication to surgery on pain pathways, and in extreme degrees argues for psychosurgery.

The operative mortality of major surgical procedures for pain relief relates directly to the patient's general condition. In otherwise healthy persons, the mortality is negligible, but among patients already weakened by their disease the surgical risk becomes an important consideration. If patients are properly selected the overall mortality for all surgical procedures should not exceed 5%.

Spinal Sensory Rhizotomy

Division of posterior spinal roots interrupts all sensation and renders the denervated area totally anesthetic. Consequently, spinal sensory rhizotomy cannot be applied to pain in an extremity and in sacral segments carrying sensation from the bladder and rectum. For unexplained reasons denervation of an extremity not only renders the limb useless but also proves unsatisfactory in terms of complete relief of pain. Spinal sensory rhizotomy can be performed on one or both sides.

Rhizotomy of C1 through C4 is quite effective for pain in the neck and occipital region.

Pain in the thorax and upper abdomen is ideally suited to sensory rhizotomy unless the pain extends over an area so wide that denervation would require division of an unreasonable number of sensory roots. One or preferably two roots above and below the painful areas should be divided to assure complete relief. Applied to pain in the cervical and occipital regions, thorax and upper abdomen, spinal sensory rhizotomy should yield satisfactory results in a higher percentage of patients. Subsequent extension of pain beyond the denervated area accounts for most late failures.

Spinothalamic Cordotomy

Since its introduction in 1911 spinothalamic cordotomy has become an accepted neurosurgical procedure. Because spinothalamic cordotomy interrupts only those fibers subserving pain and temperature leaving intact the modalities of touch and position sense, cordotomy can be advised for extremity pain. The procedure can be performed on one or both sides either in the upper thoracic or in the upper cervical spinal cord. High thoracic cordotomy is applicable to pain in the pelvis and lower extremities, but cannot be relied upon to relieve pain originating above the umbilicus. High cervical cordotomy has produced better results in our hands and the procedure offers technical advantages over thoracic cordotomy. Whereas bilateral thoracic cordotomy can be

performed in one stage, bilateral high cervical cordotomy must be done in two stages because incision of the spinal cord at this level produces transient weakness of the diaphragm and accessory muscles of respiration. Chest pain can be relieved by high cervical cordotomy, but pain in the distribution of the brachial plexus can be completely relieved in no more than one-half of patients. Pain arising from malignant invasion of the brachial plexus, usually due to direct or metastatic extension of breast and lung tumors, has been the most difficult pain to relieve by surgical means. If a patient fulfills other criteria for surgery, we currently recommend high cervical cordotomy under local anesthesia for pain originating from the brachial plexus. The complications of ipsilateral extremity weakness and loss of bladder function are rarely permanent following unilateral cordotomy, but may persist after bilateral cordotomy, particularly when the procedure is performed at one sitting.[20, 26] Cervical cordotomy has the added disadvantage of producing temporary impairment of respiratory muscles, which in the case of chest pain usually impairs the more normal lung. Despite these disadvantages, cordotomy produces satisfactory relief of pain in 3/4 of all patients followed to the time of death.[20] High cervical cordotomy is applicable to pain below the neck and when performed under local anesthesia is tolerated surprisingly well. Sensory rhizotomy of C1 to C4 can be performed at the same time to control painful cervical metastases.

Percutaneous Radiofrequency Cordotomy

In 1965 Rosomoff reported a percutaneous technique for interrupting the lateral spinothalamic tract in the cervical region.[22] The procedure involves percutaneous placement of a needle introduced between the C1 and C2 vertebrae and destruction of the anterolateral quadrant by radiofrequency coagulation. Air introduced into the subarachnoid space outlines the anterior surface of the spinal cord enabling the operator to introduce the electrode under fluoroscopic or x-ray control. Although Rosomoff reported impressive results using this technique, we abandoned the procedure at the end of a series of 25 patients because relief of pain was uncertain, beneficial effects were temporary, and complications were frequent and lasting. In our hands open surgical cordotomy has given superior results with fewer complications.

Trigeminal and Glossopharyngeal Rhizotomy

Unilateral pain in the face, mouth and throat can be controlled by an intracranial section of the trigeminal and glossopharyngeal nerves. Tumors giving rise to pain in these sites often spread to involve cervical nodes in which case the procedure is combined with an upper cervical sensory rhizotomy. Highly satisfactory results can be obtained in the management of unilateral pain, but bilateral pain constitutes an absolute contraindication to the procedure. The anesthesia produced by trigeminal and glossopharyngeal rhizotomy causes little difficulty. The upper fibers of the vagus nerve should be divided in addition to the fifth and ninth nerves when pain originates from structures in or near the ear.

Frontal Leukotomy and Its Modifications

Surgeons have attacked the frontal lobe and its connections since Moniz introduced the procedure 30 years ago. Although frontal leukotomy does not interfere with the patient's ability to appreciate pain, the procedure alters his psychological or affective response to pain. The objectionable effect of extensive frontal operations involves alterations of personality. Ideally, the change in personality should be solely beneficial, the patient becoming less sensitive to pain without becoming any less sensitive to his social environment. The undesirable effects produced by standard leukotomy are inability to profit by experience, reduction in restraint, and the appearance of selfishness, facetiousness, and moral deterioration. In some manner frontal leukotomy modifies narcotic withdrawal and abrupt termination of narcotics following surgery is not accompanied by the full-blown abstinence syndrome, even in heavily addicted patients.

Selective leukotomy has been proposed as a means of obtaining satisfactory amelioration of pain with maintenance or minimal alteration of intellect and personality structure. The more extensive operations tend to achieve greater

relief from pain, but also are more likely to produce socially crippling defects of personality. Our present method of selective frontal leukotomy involves destruction of the frontal cingulum fasciculus, a white fiber tract connecting the medial frontal cortex, the anterior thalamic nuclei and the rostral midline and intralaminar nuclei with the hippocampal formation.[5] Standard frontal leukotomy destroys this tract more anteriorly. Destruction of the cingulum modifies response to pain without producing objectionable alterations in personality.

Frontal cingulumotomy is indicated when extreme emotional lability or mental depression accompanies chronic pain. The very personality structure which contraindicates cordotomy or rhizotomy constitutes the strongest indication for this form of psychosurgery. While generally considered a procedure of last resort, frontal cingulumotomy has definite indications and when properly applied to selected patients provides a satisfactory solution to pain problems unsuitable for other forms of therapy.

Non-Surgical Methods of Pain Relief

Medication taken by mouth would provide the simplest solution to the relief of chronic pain, but drugs which can be taken by mouth fail to relieve severe pain. The psychic and physical deterioration produced by narcotics renders them unsuitable except on a short-term basis. Chemical interruption of pain pathways avoids the disadvantages of a major surgical procedure, but if simpler and equally effective relief of pain could be achieved by non-surgical means, pain surgery would fall into disuse which it has not. However, non-surgical methods should be tried in selected patients, and currently available techniques will be discussed briefly. Peripheral nerve blocks have seldom been effective in our hands and will not be considered further.

Chemical Destruction of Spinal Nerve Roots

Subarachnoid injection of alcohol has never achieved great popularity because of unacceptable complications, namely rectal and bladder incontinence and motor paralysis. Even these complications might be acceptable if the procedure provided satisfactory and lasting relief of pain. Fewer complications have followed selective injection of alcohol in the cervical and thoracic regions, but the procedure is painful, and the duration of pain relief is variable. Fewer than one-half of patients are relieved of pain even temporarily, and the procedure presently has few advocates.[9]

In 1955, Maher reported relief of chronic severe pain by intrathecal injection of phenol solutions.[17] He emphasized the safety of this procedure as compared to intrathecal alcohol injections and reported a relative lack of disabling complicaitons. Mark and co-workers in this country employed a mixture of phenol in Pantopaque,[18] and under fluoroscopic control placed the hyperbaric solution in contact with the appropriate nerve roots. They reported complete relief of pain in 25% of patients. Although Maher concluded that phenol acted selectively on C fibers and had relatively little effect upon larger sensory and motor fibers, subsequently animal experiments and post-mortem studies in man have shown that phenol produces unselective myelin degeneration.[4, 15, 24] Phenol is much safer for subarachnoid injection than alcohol, but phenol does not cause selective destruction of pain fibers in the roots or spinal cord, and in our experience relief of pain has been incomplete, effects have been temporary, and damage to motor roots has been a frequent and lasting complication.

X-ray Therapy

Radiation therapy often provides satisfactory pain relief. Temporary aggravation of pain at the initiation of radiotherapy indicates radiosensitivity and anticipates a favorable response. Relief of pain in responsive regions usually occurs within one to two weeks. In the past radiotherapists have spread treatment over a period of several weeks, but recent experience suggests that delivery of the entire dose in a single treatment may be equally or more effective.

The painful osseous metastases from carcinoma of the breast often respond to relatively small amounts of radiation, and x-ray therapy is clearly the initial procedure of choice in this situation. Relief of pain due to malignant invasion of soft tissues and major nerve trunks correlates closely with radiosensitivity of the primary tumor. Because of its general avail-

ability and virtual freedom from complications, radiotherapy should be considered early in the course of pain due to malignant tumors.

Narcotic and Non-Narcotic Medication

All patients with cancer pain receive narcotics at some time during the course of their illness. Narcotic analgesics must be correctly selected and expertly administered to obtain optimum results.[7] All potent analgesics are addicting, but in the patient with a limited life expectancy addiction of itself is a minor consideration. The greatest single disadvantage of narcotic addiction is its adverse effect at the highest intellectual level. Addiction produces dulling of the intellect and psychic alterations which have highly undesirable effects on behavior. The cancer victim drugged into a dulled state of social and personal indifference represents a compromise wholly acceptable neither to the patient nor to his family.

Non-narcotic analgesics relieve pain of low intensity, but prove relatively ineffective in the management of more severe pain. Non-analgesic drugs, such as Dilantin®[8,10] and mephenesin carbamate,[11] have been effective in the treatment of trigeminal neuralgia and tabetic pain, but have found no place in the management of cancer pain. Hormone therapy and endocrine surgery for breast and prostate cancer have an important role in pain relief but fall beyond the scope of this paper.

Chemotherapy with anti-cancer drugs may relieve pain through two separate mechanisms. Pain may disappear following the administration of an effective agent, relief of pain occurring secondary to direct anti-tumor action. Neurotoxic effects of certain anti-tumor agents provide a second mechanism for pain relief independent of anti-tumor effects. Woodhall and co-workers have documented histological alterations in peripheral nerves following regional chemotherapy.[16,27] Damage to myelin sheaths and peripheral axons explains why pain relief occurs in regions involved by drug-resistant tumor. Neurotoxic effects of chemotherapeutic agents are reversible and consequently relief of pain is only temporary.

Summary

Palliation of incurable cancer often involves the management of pain. Few problems confronting the physician are more distressing than the patient with painful cancer. Careful consideration of the patient's personality, the cause and location of his pain, and knowledge of available means of obtaining relief are prerequisite to successful management of chronic pain. The patient requiring more than codeine by mouth becomes a candidate for specific pain-relieving measures. If effective, radiation therapy represents a near-ideal solution which most often applies to painful osseous metastases. Patients whose life expectancy exceeds three months should be considered for surgical procedures. The indications and contraindications for spinothalamic cordotomy, spinal and cranial rhiotomy, and frontal cingulumotomy have been discussed. Surgical procedures should produce relief of pain with minimal sacrifice of essential function. Surgical methods of pain relief should be considered carefully before accepting a narcotic addiction as the only means of managing the patient with cancer.

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Disseminated Histoplasmosis†

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A proven case of disseminated histoplasmosis is reported. The patient was apparently healthy before onset and lived in Louisville, Kentucky. Amphotericin B treatment was given for twelve days without improvement.

Introduction

HISTOPLASMOSIS is endemic in the Ohio Valley. The disease usually presents itself as a benign respiratory infection in children, which heals without treatment. Residual pulmonary calcification may or may not occur. In spite of the high incidence of this disease the disseminated form is rarely seen. When it does occur it is often associated with debilitating malignancy or an overwhelming exposure to bird droppings. A proven case in an apparently healthy urban woman is extremely unusual and seems worthy of reporting.

Case Report

M. P. a 72 year old white female was well and active until September 1965. She then slowly and progressively developed fatigue, anorexia, weight loss, dyspnea, unilateral and then bilateral dependent edema, abdominal cramps and diarrhea.

In December 1965 she was hospitalized elsewhere with a diagnosis of arteriosclerotic heart disease and treated with digitalis and diuretics. No benefit resulted.

On January 4, 1966 she was hospitalized for progression of the above symptoms.

Physical examination revealed a chronically ill appearing female with a blood pressure of 100/50, pulse 120, respiration 24, temperature 98.4, normal color, no venous distention, clear lungs, normal heart size and rhythm with a soft apical systolic murmur. No abdominal organs were palpable. Pelvic and rectal examination was normal. Moderate pitting edema of her feet and ankles was present.

Urinalysis, sedimentation rate, fasting blood sugar, VDRL and bilirubin were all normal. Other laboratory findings were as follows: BUN 30 mg.% cholesterol 102 mg.%, alkaline phosphatase 11 Bodansky units, cephalin flocculation 4 plus in 48 hours, serum Na 126 mEq/L, potassium 3.1 mEq/L, CL 88.1 mEq/L, CO_2 27.4 MM/L, PBI 4.2 mcg.%, T-3 uptake 24%, urinary excretion of 17-KS 2.9 mg/24 hrs. and 17-KGS 2.9 mg/24 hrs., total serum protein 5.0 gm.% with albumin 1.8 gm.%. ECG revealed a left bundle branch block. X-ray examination of the chest, complete GI series, I.V.P., and the lateral skull were all normal.

A diagnosis of adrenal cortical insufficiency, etiology undetermined, was made and patient was started on prednisone and salt. This therapy produced an immediate improvement in strength, appetite, electrolytes, and to a lesser extent her blood pressure. There was also a gradual increase in edema requiring an occasional mercurial injection. After three weeks hospitalization she was discharged on cortisone acetate 25 mg. b.i.d.

On February 12, 1966 she was readmitted because of the sudden onset of a semicomatose state. Marked wasting (weight 90 pounds), stiff neck and hypotension were again found. The patient was febrile for the first time and widespread ecchymoses were noted.

Urinalysis was normal. Hemoglobin was 7.5 gm.% with a WBC of 2,563. Platelet count

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was 82,000. Na was 120 mEq/L, potassium 2.2 mEq/L, CL 87.6 mEq/L and CO_2 29.9 MM/L. BUN was 42 mg.%. L. E. cell preparation was negative.

Hypertonic saline with additional potassium and corticosteroids produced some temporary improvement but the patient remained febrile in spite of penicillin. A bone marrow aspiration for culture and microscopic examination revealed, much to our surprise, histoplasmosis. The bone marrow was otherwise normal. Blood and the spinal fluid were also obtained and all three cultures grew out histoplasmosis. (See picture).



From left to right are pure cultures obtained from bone marrow, blood, and spinal fluid.

Amphotericin B therapy was started immediately. She was given 10 mg., 12.5 mg., 15 mg., 20 mg., 25 mg., 30 mg., and 35 mg. on successive days and then 35 mg. daily. This was administered over a six hour period in 5% dextrose in water with potassium and hydrocortisone added. Fluids and food by nasogastric tube and several whole blood transfusions were given. Her condition deteriorated steadily and death occurred on March 1, 1966 after 12 days of amphotericin B treatment.

Discussion

Samual Darling[1] first described disseminated histoplasmosis in 1906. He reported a case of a 27 year old negro with vomiting and fever. The patient lived one day. Organisms were found in the lung, plasma, spleen, bone marrow and lymph nodes. Dr. Darling proposed the name of histoplasma capsulata.

The portal of entry is usually the lung but may be the gastrointestinal tract or skin.

A high incidence of associated malignancy, usually lymphoma, has been noted.[2] Long term corticosteroid therapy also seems to facilitate the dissemination of this disease.[3]

The diagnosis is usually made by smear and/or culture. The easiest to obtain and the most reliable tissue is bone marrow. Most diagnoses that are made before death are the result of marrow aspiration.[3,4]

Amphotericin B has been widely used in the treatment of disseminated histoplasmosis. If the diagnosis is made before the patient is in a terminal state and there are no complicating factors, the treatment is often successful. A small dose of the drug is infused on the first day and the dosage gradually increased daily until a level of 1.0 mg. to 1.5 mg. per kilogram of body weight is reached. If toxic manifestations appear, the dose is reduced temporarily. Renal toxicity is the most serious complication and the BUN is usually used as a guide to dosage level of the drug. The nausea, vomiting and headache associated with amphotericin B can usually be treated symptomatically. If treatment is going to be successful, improvement appears in ten to fourteen days. Eight to twelve weeks of treatment is recommended for cure and on occasion retreatment is necessary.

Another drug, X-5079C, has been reported in the treatment of disseminated histoplasmosis.[5] This drug has the advantage of being relatively non toxic and may be given intramuscularly. The final place of this drug in the treatment of disseminated histoplasmosis must await further clinical trial.

Summary

A 72 year old previously healthy urban female developed a progressive illness of six months duration. There was clinical evidence of involvement of the heart, liver, kidney, gastrointestinal tract, bone marrow, central

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Extended Radical Mastectomy By the Method of Sugarbaker: A Preliminary Evaluation†

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Extended radical mastectomy can be accomplished with a morbity comparable to radical mastectomy. The rationale of treating breast cancer by this method is discussed.

CONTROVERSY continues concerning the management of regional lymph nodes in carcinoma of the breast. On the one hand, some[1,5] believe that the lesion is incurable if lymph node involvement is present and therefore advise simple mastectomy. Others uphold the value of removing axillary lymph nodes, but maintain that previous attempts at cure by classical radical mastectomy were defeated by the presence of involved internal mammary nodes in as many as half the patients with involved axillary nodes.[2,3,6,7] Both groups offer suggestive evidence to support their contentions, but statistically significant data has been lacking.

Sugarbaker[6] recently published a comparison of a sequential series of 88 patients treated by classical radical mastectomy and 158 patients treated by extended radical mastectomy in which internal mammary nodes were included in the resection. Results indicated that there was a significant improvement in the 5 year survival ($p = < .01$)* in patients treated by extended radial mastectomy. The morbidity for the extended procedure was also said to be the equivalent of conventional radical mastectomy. This report has stimulated our evaluation of the morbidity, mortality and therapeutic benefit of this procedure at the University of Kentucky Medical Center. This communication pertains only to the morbidity of this procedure in our hands.

Patient Selection

Patients with axillary or chest wall fixation, extensive edema or ulceration of the breast, numerous satellite skin nodules or evidence of inflammation were considered inoperable.

A total of 62 patients with carcinoma of the breast were seen between February, 1964 and September, 1965. Forty had recurrent disease following previous therapy. Of the remaining 22 patients with primary untreated cancer, 4 were inoperable by the criteria noted above. Eighteen were treated by operation for cure. Two had only classical radical mastectomies because of previous contralateral mastectomies for cancer of the other breast. The remaining 16 patients underwent extended radical mastectomy.

Methods

Sugarbaker's operation is essentially a simplification of Urban's technique of extended mastectomy.[7] We have adopted features of both. A conventional radical mastectomy is done leaving the dissection of the attachments of the pectoralis major from the rib cage until

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**Our calculation by X^2*

the last part of the operation. The first interspace adjacent to the sternum is opened and the internal mammary vessels identified and ligated. The fourth intercostal space is then opened and the internal mammary vessels again ligated and divided. Using a Lebshe sternal knife, the sternum is split from the first to the fourth interspace 5 mm. from its lateral border (Fig. 1). The pectoralis muscle is freed from its attachments at the lateral aspect of the rib cage to a point 5 cm. from the sternum. The 2nd, 3rd and 4th ribs with their interposed intercostal muscles are cut with bone cutting instruments and scissors. The entire specimen containing the breast, muscles and a 5½ cm. strip of chest wall along with the underlying internal mammary chain and the underlying parietal pleura is removed en bloc.



FIGURE 1. Sagittal section of the chest showing the incision along the sternum using the sternal knife. The rest of the specimen is elevated from the chest wall to the point where the ribs will be incised as shown by the dotted line.

A #30 French, plastic chest tube in inserted in the 9th intercostal space in the midaxillary line and subsequently attached to underwater drainage. No special precautions are taken in closing the skin and subcutaneous tissue directly over the chest wall defect except that care is taken to maintain an adequate medial skin flap, thus placing the skin suture line lateral to the chest wall defect.

The defect is closed by mobilizing the medial flap of mediastinum and suturing it laterally with a running 3-0 chromic catgut suture. The skin flaps are closed over the chest wall

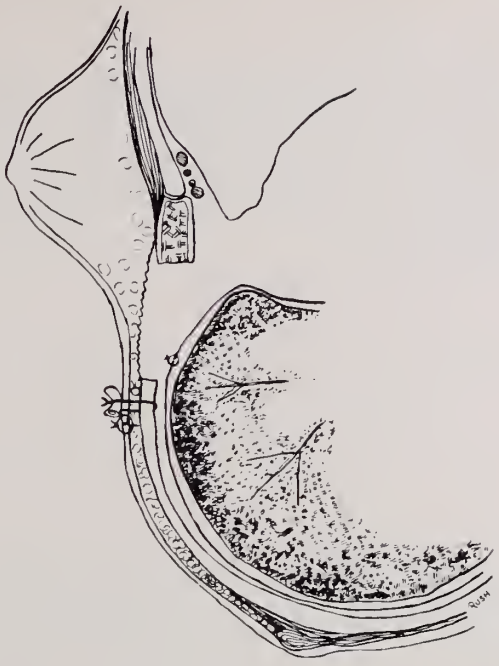


FIGURE 2. Closure of the pleura and of the skin flap over the defect left by removal of the block of chest wall.

defect in a conventional manner except that the medial flap is stinted to the chest wall with Dacron® sutures tied over dental rolls in a manner suggested by Urban[7] (Fig. 2). Suction catheters are used under the skin flaps and the skin edge is sealed with a plastic spray. No other dressing is used. The chest tube is removed in 48 hours and the suction catheters in 72 hours. The postoperative defect differs little from a conventional radical mastectomy (Fig. 3).

Results

Sixteen consecutive patients ranging in age from 35 to 71 years were operated upon, using this method. One patient was a male. The average amount of blood given at operation was 800 cc. The procedure was performed by the attending staff on 2 patients and by the resident staff in the remainder. The average length of operation was 3 hours and 45 minutes. Three patients had a slight slough of skin at the suture line and one had a superficial wound infection. No difficulty with intrapleural effusion, infection or subsequent pneumothorax was encountered. Hospitalization averaged 12 days following operation. There were no postoperative deaths.

Eleven of the sixteen patients had axillary lymph node metastasis. In four (28%) the internal mammary nodes were also involved. Of the four patients with internal mammary node involvement the primary lesion was in the upper outer quadrant in two; was a large subareolar lesion in one; and was in the lower inner quadrant in one. No patients had tumor within the internal mammary nodes without concomitant axillary involvement.

All but one of the patients operated on are alive at present, 3 with recurrent disease. Of the 4 patients with positive axillary and internal mammary nodes, three have no evidence of recurrence, the fourth has developed a distant metastasis.



FIGURE 3. The postoperative defect. Temporary paradoxical motion in the flap is minimal and has not been a problem.

Discussion

This operative experience confirms Sugarbaker's contention[6] that modified internal mammary node dissections can be performed without significant increase in morbidity.

Sufficient evidence is now available to confirm that internal mammary nodes are involved in 50% of patients having axillary node involvement with mammary carcinoma. This often pertains regardless of the location of the primary in the breast.[2,3,6,7] If the surgeon believes that removal of involved lymph nodes is beneficial, logic dictates routine removal of internal mammary as well as axillary nodes. If this extension of the procedure did not benefit patients in terms of a better asymptomatic, five-year survival, it would suggest that simple mastectomy is the only worthwhile surgical procedure. At least one randomized series was reported comparing extended radical mastectomy with simple mastectomy and radiation therapy. In this series all nodes were treated either by operation or radiation and the question of the effect of operation alone on patients with lymph node involvement was not answered.[4]

Sugarbaker's data was derived from a sequential series.[6] We propose that a randomly selected concurrent series comparing radical mastectomy and extended radical mastectomy would have great value in clarifying the question of the best available therapy for patients with positive axillary nodes. Such a study would be better accepted and more likely accomplished by American surgeons than a comparison of simple versus radical mastectomy even though directed to the same problem.

Summary and Conclusions

A series of 16 consecutive patients with internal mammary node dissections by the method of Sugarbaker is reported. Morbidity of the procedure in terms of blood loss, operative time, hospital time and rate of complications did not differ appreciably from the morbidity of conventional radical mastectomy. It is proposed that a randomly selected concurrent series of radical mastectomies and extended radical mastectomies would have value in determining the general question of the usefulness of resection of lymph nodes involved by neoplasm in the treatment of carcinoma of the breast.

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SPECIAL ARTICLES

Education for Family Practice, Public Law 89-97, Selective Service Among Items Considered by AMA House of Delegates in Las Vegas*

The editors of The Journal are printing a detailed summary of the actions of the AMA House of Delegates during the 20th Clinical Convention, November 27-30 in Las Vegas. Because of its length, it is being carried in installments, the first part in the January issue of The Journal, and the concluding part in this issue. The editors feel the actions of the House should have special significance to YOU the individual physician, and urge you to read this report.

(Continued from last month)

Recommended that *driver education* should be an integral part of the secondary school curriculum and be offered to all students;

Approved a Council on Medical Service report providing guidelines for collaboration of physician, social worker and lawyer in helping the *unmarried mother* and her child, and;

Referred to the Board, for consideration and appropriate implementation, a resolution urging the AMA to expand its program and studies in the field of *crime prevention.*

Awards and Presentations

At the Monday opening session Dr. Milford O. Rouse, AMA president-elect and former speaker of the House, was presented with a mounted gavel in appreciation of his many years of service to the House and the Association.

Contributions totaling more than $500,000 were presented on Monday to the American Medical Association Education and Research Foundation. They were as follows: Merck Sharp and Dohme, $100,000; California Medical Association, $207,985; Illinois State Medical Society, $185,000; Utah Medical Association, $12,957.50; Medical and Chirurgical Faculty of Maryland, $9,110, and American Urological Association, $1,000.

Glen W. Geelhoed of Ann Arbor, a medical student at the University of Michigan, was announced on Tuesday as first-place winner in the Norman A. Welch, M.D., Medical Ethics Essay Contest sponsored by the AMA Judicial Council. At the same session the delegates heard an address by Dr. Malcom E. Phelps, field director of the AMA Volunteer Physicians for Vietnam, who said that the American physician is making a "tremendous impression" on the South Vietnamese people.

"E. Careful attention should be given to other factors which should make the environment for family practice more favorable and serve as incentives to medical students and young physicians to enter this field.

"F. Careful study should be made of the effect of pre-medical programs and the admission procedures, curricula and student evaluation policies of medical schools upon the production of family physicians."

Delegates and other interested AMA members also attended an open hearing Tuesday morning on the report of the Citizens Commission on Graduate Medical Education, which is similar in many respects to the report of the Ad Hoc Committee on Education for Family Practice. The Commission report is still under study by the AMA Board of Trustees and Council on Medical Education. The House of Delegates urged every physician and medical society to study the report (commonly called the "Millis Report"), to evaluate it and to present comments and critique to the Board prior to the next session of the House.

Public Law 89-97

The House adopted a resolution urging that the American Medical Association advise the Department of Health, Education, and Welfare that the

*Report of F. J. L. Blasingame, M.D., executive vice president, American Medical Association.

present requirements for certification and recertification have proven highly objectionable, unnecessary, and do not contribute to the quality of medical care.

It also recommended that the American Medical Association endeavor to bring about repeal of those portions of PL 89-97 in which the requirement for physician certification of medical necessity appears.

Selective Service Proposals

The resolution concluded by suggesting that the fiscal intermediaries and the American Hospital Association be advised that AMA will be available to assist in the development of appropriate amendments to this legislation. The purpose of this consultation would be to discuss the complexities of the present requirement and to invite participation in the development of amendments to the law which will be professionally acceptable and administratively workable.

The House also adopted a resolution declaring that the AMA strongly support amendment of the Social Security Act, including Title XIX, to permit payments without assignments for medical care of the patient.

The House rejected three resolutions and one report defining usual, customary and reasonable charges. Instead, it adopted a resolution which said that the definitions of the words "usual," "customary" and "reasonable" be considered, within the fundamental framework of individual determination, the responsibility of the constituent state medical societies, with the understanding that the advice and counsel of the AMA be made available to those states requesting such assistance.

The House adopted a report seeking federal legislation to establish a National Commission on Health Resources and Medical Manpower. The commission would revise the "doctor draft" system and establish physician allocation priorities to maintain a proper balance of health personnel in civilian and government service.

The report, prepared by the Council on National Security, cited three basic flaws in the Selective Service System as it pertains to the selection of physicians for military service: 1) There is no medical group directing the allocation of physicians; 2) There is no medical group directing the priorities to be used for calling physicians to active duty; 3) There is a need for a stronger medical voice within the Department of Defense.

The proposed commission would be appointed by the President with consent of the Senate. It would replace the Health Resources Advisory Committee and the National Advisory Committee to Selective Service.

Prescribing of Drugs

The House adopted a report by the Board of Trustees reaffirming the position of the AMA regarding the prescribing of drugs. The report states:

"The present policy of the American Medical Association is that physicians should be free to prescribe drugs generically or by brand name for *all* of their patients, whether they are paying, Medicare, or indigent patients—the primary considerations being the best interests of the patient. Medical considerations must be paramount in the selection of drugs. In addition, the physician also has an obligation to be mindful of the economic consequences of the treatment he prescribes."

Choice of a Laboratory

The House adopted a report of the Judicial Council which answered questions which have been raised about laboratory services. The report stated:

"Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory because it provides him with low cost laboratory services on which he charges the patient a profit, is derelict in not acting in the best interests of his patient. However, if reliable quality laboratory services are available at lower cost, the *patient* should have the benefit of the savings."

Statement on Chiropractic

On recommendation of the Board of Trustees, the House adopted a policy statement submitted by the Committee on Quackery. The statement notes "the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease" and pointed out that "decisions by the nation's highest courts (justify) the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic."

Statement on Alcoholism

The House reaffirmed the 1956 policy statement on admission of alcoholics to general hospitals. The statement urged hospital administrators and medical staffs to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, with such admissions being made after due examination, investigation and consideration of the individual patient. The House, in Las Vegas, recommended more adequate implementation of the 1956 statement and urged that "insurance companies and prepayment plans be encouraged to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism."

KMA's Ad Hoc Committee Studies Fragmentation of Health Services Provided By State of Kentucky*

THE KMA Ad Hoc Committee to Study Health Services in Kentucky has spent two days in studying the fragmentation of the health services in Kentucky, according to Gabe A. Payne, Jr., M.D., chairman. A third meeting is planned early in February.

(In order that all KMA members might have a better understanding of the present organization structure of the agencies of state government that provide health services, Dr. Payne's committee has recommended the State Department of Health prepare supplementary information for this issue of The Journal. This material is carried adjacent to this article in a "gatefold" insertion. It is suggested that this sheet be removed and held in file for your future reference. The committee is indebted to Mr. William Wester, deputy commissioner, State Department of Health, for this illuminating material.)

"As directed by the Board of Trustees," Doctor Payne said, "we were faced with the fact that between the time that the Board of Trustees created our committee and the time of our meeting, the Congress had passed Senate Bill 3008, which is now known as PL 89-749." Doctor Payne continued, "this bill in its provisions will be quite well known to most of the readers and I will not go into detail about it except to say that it will allow the states to receive federal grants to study the health services in the respective states for the purpose of co-ordinating the various health programs. This law further will provide that all of the monies now coming to Kentucky, in various designated amounts to different types of health programs, in the future will come in one lump sum and will be spent according to the plans which the State will adopt.

"Our committee felt that we should immediately proceed to do some planning in the light of this new bill. We, therefore, presented to the KMA Board of Trustees and it was unanimously accepted by them at the December 7, 1966 meeting a statement of policy of the Association which reads as follows:

1. The Kentucky Medical Association requests that the Governor in implementing PL 89-749 designate the Department of Health as a comprehensive state planning agency under the comprehensive state health planning act with the advice and assistance of KMA.
2. The Kentucky Medical Association requests the Governor to appoint a state health planning council composed of not more than 25 members giving representation there on to the following:
   a. Appointed physician member of the State Board of Health. (1)
   b. Representatives of the Department of Health. (2)
   c. Representatives of the Department of Mental Health. (2)
   d. Physicians from the private practice of medicine (3) (at least one of whom should be affiliated with some local health agency).
   e. Dentists. (1)
   f. Pharmacists. (1)
   g. Hospital administrators. (2)
   h. Private citizens. (13 qualified by education, their knowledge of state government and interest in health programs one of whom should be the Chairman and vote only in case of a tie.)

"This recommendation we have forwarded to Governor Edward T. Breathitt. At our second meeting, we spent approximately three hours in studying the current setup of governmental health services in the State of Kentucky, the various departments, commissions and other groups where any health services or health activities are carried out. The Statutes relating to these various activities were given careful attention. It is currently the objective of our committee:

Because of the concern of the KMA Board of Trustees of the growing fragmentation of health services provided by the State of Kentucky, it appointed a special committee to study the matter. This article is a progress report written by the chairman of the committee.

1. Work with the Department of Health, Mental Health and other state health groups in assuring strong medical leadership in the implementation of PL 89-749.
2. After further study and various consultations, it is our hope to be prepared to present to the planning council, when it is appointed, a KMA endorsed and strongly supported overall health services plan for the state."

"Any suggestions and help which you may care to offer, we trust that you will feel free to contact any of the members of the committee listed below."

Doctor Payne further stated, "I cannot conclude this report without paying tribute to two members who have contributed greatly to our first two meetings and who for different reasons will no longer be on the Committee—Charles F. Blankenship, M.D. has submitted his resignation effective January 31, 1967, to become Deputy Commissioner of Health for the State of Kentucky on February 1, 1967. Doctor Blankenship's presence on the Committee will be greatly missed. I would not be honest if I did not say we should be highly pleased to have a man of Doctor Blankenship's stature and ability in the new position which he will assume."

"It is with a great deal of sadness," Doctor Payne said, "that we will read elsewhere in this issue of the untimely demise of Louis M. Foltz, M.D. Doctor Foltz had been most active on the Committee, being at both of the meetings and only two nights before he was taken ill, I had personally had a long telephone conversation with him referrable to the Committee activities. His passing is not only sad to his family and friends, but a great loss to medicine in the State of Kentucky."



See "gatefold" organizational chart and explanatory material of State Health Service

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Make Plans Now . . .

for the

1967 KMA Interim Meeting

April 19-20

Ken-Bar Inn, Gilbertsville

1. DEPARTMENT OF EDUCATION under KRS 163.110 through KRS 160.240 has responsibility for rehabilitation services to persons over the age of 16 whose impairments render them unemployable. The State Board of Education has power to promulgate rules and regulations. Supported basically from federal monies by Acts of Congress dating back to 1920.

2. DEPARTMENT OF CHILD WELFARE under KRS 199.00 has responsibility for the health of its wards in State institutions and foster homes. Children's Advisory Council under KRS 199.840 advises the Commissioner of Child Welfare on policies with respect to "programs and responsibilities."

3. DEPARTMENT OF ECONOMIC SECURITY under KRS 205.510 - 991 has the responsibility for the provision of medical services for individuals eligible under Title XIX of the Social Security Amendments. This responsibility is jointly administered by contract with the State Department of Health. The individual responsibility of each Department are spelled out in KRS 205.570. KRS 205.540 establishes the Advisory Council for Medical Assistance and spells out its functions and responsibilities.

4. DEPARTMENT OF HEALTH under KRS 211. is vested with authority to do all things necessary to protect and improve the health of the people. In order to carry out this responsibility the Department has the following administrative units, boards and councils.

   4.1 State Board of Health - Adopts rules and regulations necessary to control all matters set forth in KRS 211. that have not been delegated to some other agency, this includes medical and hospital licensure, state plumbing codes and a general advisory capacity to the Commissioner on all matters relating to the Department. It also appoints county boards of health pursuant to KRS 212.020.

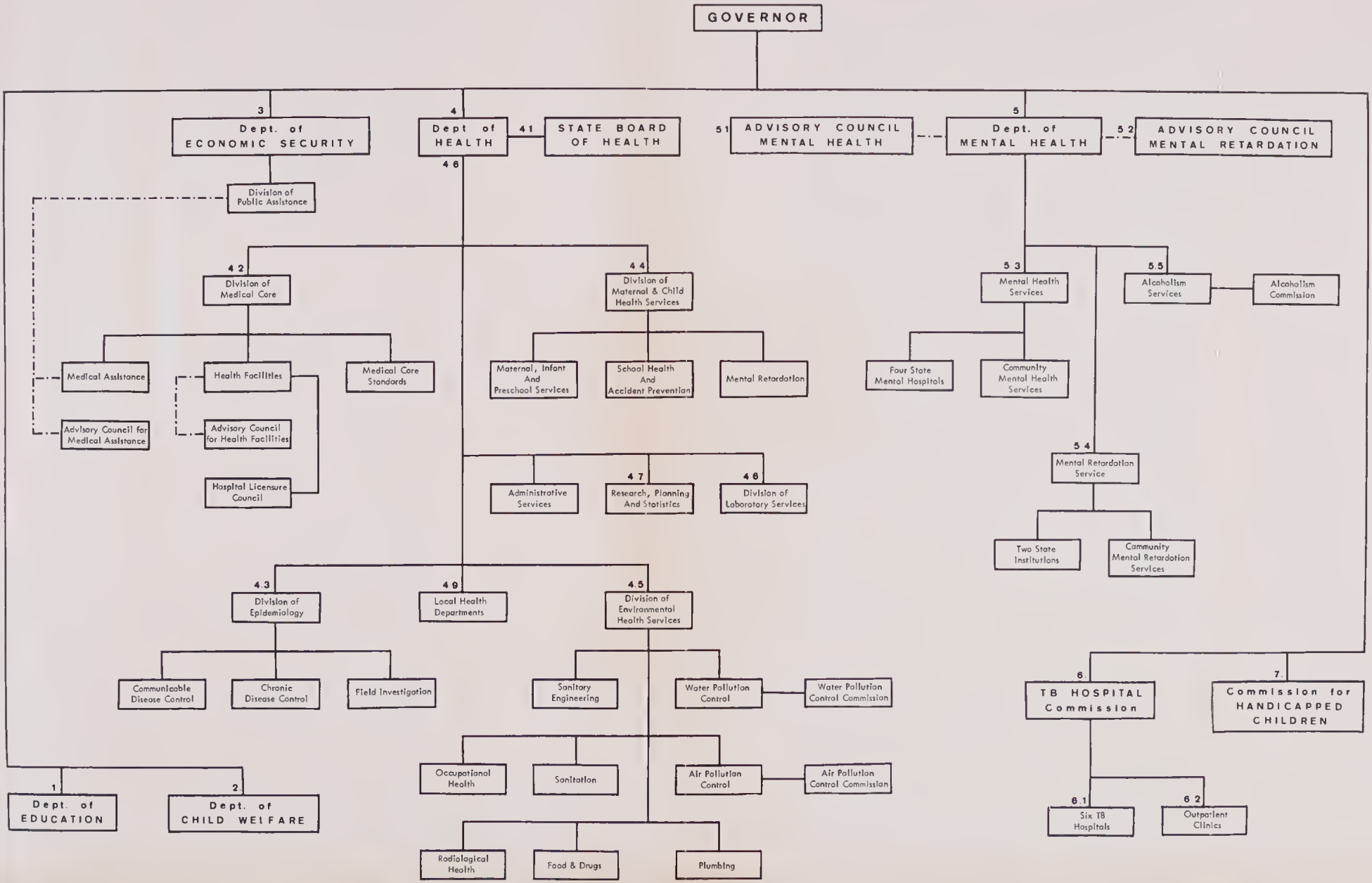
   4.2 The Division of Medical Care has three primary functions: (1) The Medical Assistance Program has responsibility jointly with the Department of Economic Security for the provisions of medical care services for eligible individuals of Title XIX of the Social Security Amendments. KRS 205.540 establishes the Advisory Council for Medical Assistance and spells out its functions and responsibilities. (2) Health Facilities Program has responsibility for the administration of Public Law 88.443, Section 604 (A)(3) planning and construction of hospitals and medical facilities. Public Law 88.164, Section 134 (A)(3) planning and construction of facilities for the mentally retarded and Public Law 88.164, Section 204 (A)(3) the planning and construction of community mental health centers. These responsbilities and the Advisory Council for Health Facilities which advises the Commissioner of Health were placed in the Department of Health by Executive Order of the Governor. Also under KRS 216.400 this office is responsible for the licensure of hospitals and nursing homes. (3) Medical Standards Program has responsibility by agreement with the Social Security Administration for the certification of providers of service under Title XVIII of the Social Security Amendments (Med-Care).

   4.3 The Division of Epidemiology administers the Departments responsibility under KRS 211.180. In order to accomplish this responsibility, the Division is divided into three Programs: Communicable Disease Control, Chronic Disease Control and a Field Investigation staff which services the entire Dement.

   4.4 The Division of Maternal and Child Health has responsibility under KRS 211. 180 (3)(4)(5) and KRS 210.040 (3) for the "protection and improvement of the health of expectant mothers, infants, preschool and school age children." This includes administrations of those sections of Title V of the Social Security Amendments which relates to this responsibility.

   4.5 The Division of Environmental Health Services is responsible for activities necessary to protect and improve the environment and in so doing protecting the public health. In order to accomplish this task, the Division is divided into eight programs (1) Water Pollution Control Commission under the provision of KRS 220. has responsibility for providing a comprehensive program for the prevention, abatement and control of water pollution. The division is the administrative arm of the Commission and the State agency responsible for administering federal law pertaining to water pollution. (2) Air Pollution Control Commission under the provision of KRS 224.310 - 991 is responsible for controling contaminates in the atmosphere of sufficient quanitites and of such characteristics that are injurious to human, plant or animal life. The Division is the administrative arm of the Commission and the State agency responsible for administering federal law pertaining to air pollution. (3) The Sanitary Engineering Program is responsible for public wastes, sewage and solid waste systems under KRS 211.180. This

ORGANIZATION OF MAJOR GOVERNMENT HEALTH FUNCTIONS IN KENTUCKY



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Program also administers federal programs relating to construction of sewage and water facilities. (4) The Sanitation Program under KRS 219.010 through 219.990 has responsibility for the general sanitary conditions of hotels, restaurants, trailer parks and other places of public use. (5) Radiological Health Program by agreement with the Atomic Energy Commission and under the authority by KRS 152.120 has the responsibility of licensing and controling the uses of fissionable materials. (6) The Occupational Health Program under KRS 211.180 has responsibility for the prevention and control of occupational diseases. (7) The Food and Drug Program under KRS 211.180 and KRS 217.145 has the responsibility for enforcing the federal Food, Drug and Cosmetic Act and Kentucky's law governing the subject. (8) The Plumbing Program under KRS, Chapter 318 has responsibility for licensing plumbers and through the regulation of the State Board of Health regulating plumbing in public buildings and enforcing the state plumbing code.

4.6 The Division of Laboratory provides laboratory services for all functions of the Department of Health and local health departments under KRS 211.190 which includes necessary branch laboratories.

4.7 The Division of Research, Planning and Statistics has responsibility for evaluation, projection and planning for future health needs and program activities of the Department and under KRS 213. The duties of registration of births, deaths, marriages and divorces are a function of the Division.

4.8 Other functions not included organizationally in any division but assigned directly to the Commissioner's Office are: The administration of county health departments, statewide nursing and dental services and Narcotic Control.

4.9 County boards of health and city-county boards of health are authorized under KRS, Chapter 212.

5. DEPARTMENT OF MENTAL HEALTH under KRS, Chapter 210 has the responsibility for the operation of all State institutions for the mentally ill and mentally retarded and for developing with other State agencies programs for the prevention of mental disease and for post-institutional care. The Department, by Executive Order by the Governor, also has responsibility for the provision of institutional services for alcoholics and for developing programs for the prevention of alcoholism. In order to accomplish these responsibilities, the Department has three basic program units which are assisted by two advisory councils and one commission.

5.1 Advisory Council of Mental Health under KRS 210.030 is directed to serve in an advisory capacity to the Commissioner of Mental Health.

5.2 Advisory Council on Mental Retardation under KRS 210.075 is directed to serve in an advisory capacity to the Commissioner of Mental Health in regard to Mental Retardation Programs.

5.3 The Department under KRS Chapter 210 operates four hospitals for the mentally ill and is developing extensive community services under federal Public Law 88-164.

5.4 The Department under KRS Chapter 210 operates two facilities for the mentally retarded and under federal Public Law 89-105 is developing community based services on a statewide basis.

5.5 The Department by virtue of an Executive Order of the Governor has assumed those responsibilities outlined in Chapter 222 of the Kentucky Revised Statutes which pertain to the prevention and treatment of alcoholism. The Chapter also creates the Kentucky Commission on Alcoholism which was created to serve in an advisory capacity to the Commissioner of Health but now functions in that capacity to the Commissioner of Mental Health.

6. STATE TUBERCULOSIS HOSPITAL COMMISSION is authorized under Chapter 215 of the Kentucky Revised Statutes to maintain and operate hospitals for the treatment of tuberculosis, histoplasmosis or other pulmonary fungus diseases.

6.1 In order to accomplish these responsibilities, the Commission has the State divided into six districts with one State hospital serving each district.

6.2 The Commission provides out-patient services to persons who have been treated and discharged from a T. B. Hospital. In addition, the Commission employees, in conjunction with the Department of Health and county health departments conduct screening clinics.

7. COMMISSION FOR HANDICAPPED CHILDREN under KRS 200.400 through KRS 200.500 has the authority to provide "such services as may be necessary to locate, diagnose, treat, habilitate or rehabilitate handicapped children". These services are provided to children under twenty-one years of age who are unable to pay for such services or who live in an area where services are not available. The Commission provides services financed under Title V of the Social Security Amendments.

New from Du Pont

Symmetrel

(Amantadine HCl)

ıe first oral chemical virostat for the prevention of influenza A_2



Influenza virus
Protein shell enclosing the core of nucleic acid (RNA)—artist's representation

The incidence of influenza A_2. In this country, where influenza is one of the leading causes of morbidity, influenza A_2 (Asian) continues to be a serious medical problem. In 1957 influenza A_2 was responsible for approximately 40,000 excess deaths in a three-month period. Since that year the most prevalent influenza virus has been A_2 (Asian).

What is Symmetrel®? "Symmetrel" (amantadine HCl) is a new synthetic chemical which acts as a molecular barrier to virus penetration. It provides for the first time specific oral medication for the prevention of respiratory infections caused by influenza A_2 (Asian) viruses—an entirely new approach in preventive medicine.

For prescribing information, see last page of this presentation

What Symmetrel® (amantadine HCl) means to you

...the first and only oral chemical agent to prevent influenza A_2 (Asian).

...not a vaccine or antibiotic, but a new synthetic chemical unrelated to any other chemotherapeutic agent.

...unique mode of action: prevents virus penetration of the host cell without affecting vital cell functions.

...specifically active against all influenza A_2 viruses tested to date.

...not indicated for the prevention of influenzal or respiratory illness other than influenza A_2 or for the treatment of established disease.

...does not interfere with normal antibody response; acts in concert with pre-existing antibody.

What Symmetrel® means to your patient

...possible immediate influenza A_2 protection when taken following suspected contact.

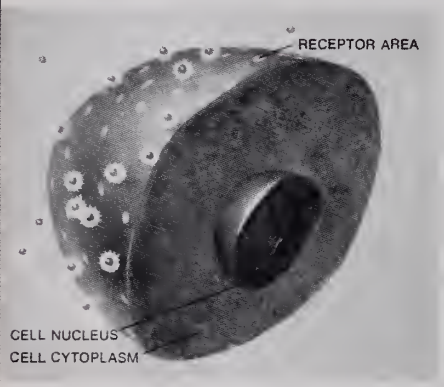
...may be particularly useful during outbreaks or epidemics and for high-risk patients in whom the occurrence of influenza A_2 is especially hazardous.

...a high degree of safety in clinical use.

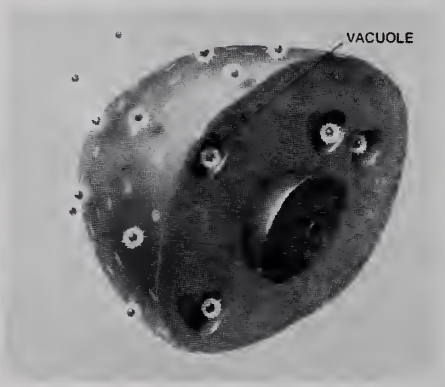
...simple once daily or b.i.d. dosage.

The mode of action of Symmetrel®

How the influenza virus invades and destroys the untreated cell



1 Viruses outside the cell attach themselves to specific cell receptor areas

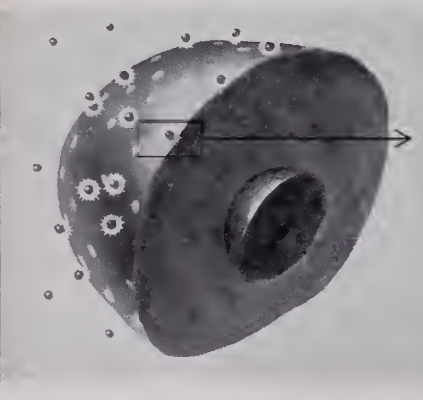


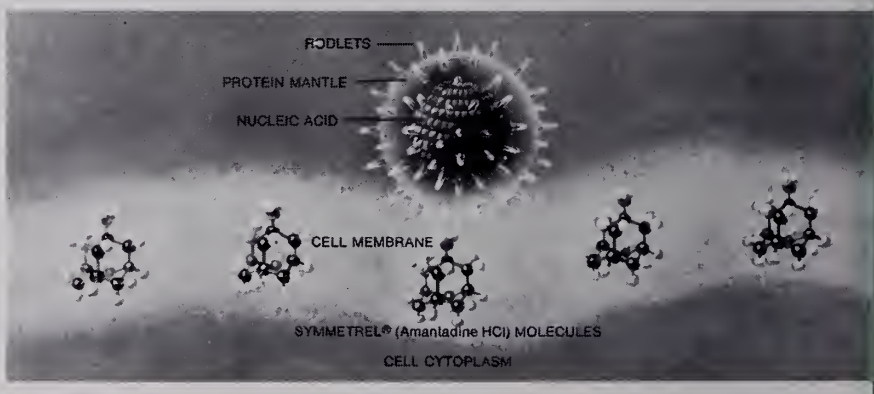
2 The virus is incorporated into a vacuole within the cell. From this vacuole the virus nucleic acid passes into the cell cytoplasm



3 The virus nucleic acid then directs the cell to produce both new virus nucleic acid and virus protein coat material which aggregate to form new virus particles. This process leads to the release of new virus particles and eventual destruction of the cell

How Symmetrel® (Amantadine HCl) prevents virus invasion[1]





Our current knowledge leads us to believe "Symmetrel" acts as a molecular barrier to influenza virus penetration. Shown here in a greatly enlarged section, "Symmetrel"—located at the cellular membrane—effectively prevents (blocks) virus penetration. Thus, "Symmetrel" does not directly destroy the virus particle but acting as a virostat prevents the cycle of virus penetration, virus replication, and cell destruction that is characteristic of virus invasion of animal cells (tissue). *Artist's conception based on current scientific knowledge.*

1. "Mode of Action of the Antiviral Activity of Amantadine in Tissue Culture", Hoffmann, C. E.; Neumayer, E. M.; Haff, R. F.; and Goldsby, R. A., Journal of Bacteriology *90*,623 (1965).

afety of Symmetrel® Confirmed. When used as indicated, is generally well tolerated. No kidney, ver, bone marrow, or hematological disturbances have been observed.

'rescribing Information

ndications: "Symmetrel" is indicated for the prevention (prophylaxis) of influenza A_2 in persons of all age roups. Early use is recommended, preferably before r as soon as possible after actual or suspected contact with individuals suffering from influenza A_2. Symmetrel" should especially be considered for igh influenza-risk patient groups such as those suffering from chronic debilitating diseases and elderly ersons.

ontraindications: Not indicated for the prevention f influenzal or respiratory illness other than influnza A_2 or for the treatment of established disease.

Warnings: Administration to patients with central ervous system disease, particularly geriatric patients vith cerebral arteriosclerosis, and patients with a istory of epilepsy or other "seizures," requires strict bservation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully medically while taking "Symmetrel." (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: *Adults:* Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: *Capsules:* Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.
Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.

DUPONT

Symmetrel®

(Amantadine HCl)

A molecular barrier to virus penetration

arrest diarrhea

in • gastroenteritis • acute infections



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride ..... 2.5 mg.

(Warning: May be habit forming)

atropine sulfate ..... 0.025 mg.

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

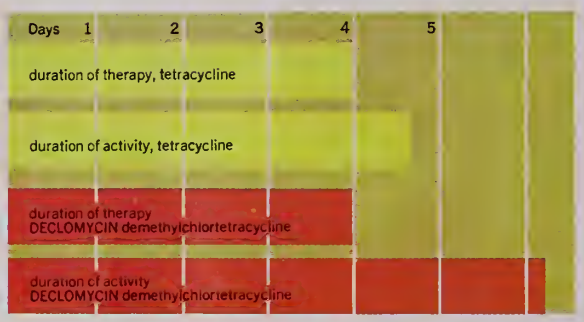
SEARLE *Research in the Service of Medicine*

why wonder about a drug

when you know

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

produces 1-2 "extra" days' activity



1-2 "extra" days' activity
after the last dose to protect against relapse

one 300 mg tablet b.i.d.
or
one 150 mg capsule q.i.d.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are comman and ordinarily mild side effects. Canfusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concamitant administration of central stimulants. Allergic or idiosyncratic reactions: maculapapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneuratic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, ogranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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695-G

EDITORIALS

A Step Ahead

TWO and one-half years ago the KMA House of Delegates authorized a positive and progressive step forward for our Association when it changed our Bylaws to require the completion on an Orientation Course by a new member within the first two years of membership.

Many of our members approved this action with tongue-in-cheek, others would not discuss it at all, and some opposed it vigorously. Today all of this has changed; and while we were one of the first states to require an Orientation Program, its success has dispelled those initial reactions.

The House of Delegates has now met on two occasions since authorizing this new concept for KMA; and even though mention of this program was not required by this governing body, on both occasions they felt it appropriate to take time to commend the course and those who took part in it.

Having had the pleasure to be the first chairman of the Orientation Committee, I observed the dedication and sincerity of the committee members who formulated the program and the time-consuming preparation of those who have appeared on it. I have seen the concerned look on our new members faces as they arrived for the program and then heard their thanks and gratitude before they left.

On April 19, the fourth KMA Orientation Program will be held and for some ten to fifteen new members this will be their final opportunity to complete the course and maintain their membership status as outlined in our Bylaws. Surely they all will be in attendance. For one hundred and eighty-seven other new members, the course is history; and they have taken their step forward and are growing with their Association.

N. LEWIS BOSWORTH, M.D.*

Chairman, KMA Council on Communications and Public Service

The Way of Eagles

AN opportunity is again approaching. Annually, KMA has been hosts for the Seniors of our two Medical Schools.

The U. of L. Day will be on Monday, March 20, with an opening address by President Pennington, in the Rankin Amphitheater, General Hospital at 11: A.M. The afternoon session will convene at the Executive Inn at 1:30 P.M. The evening program, co-hosted with JCMS, at 6:00 P.M. Dr. Thomas Haggai, renowned orator will speak.

The U. of K. will be at the Imperial House, Lexington, Kentucky 1:30 P.M. Tuesday, April 11, with opening speech by Dr. Pennington. Dinner at 6:00 P.M. with Fayette County Medical Society as co-hosts. Featuring Doctor Milford Rouse, President-elect of A.M.A.

All members of KMA are invited and urged to attend.

Fortunate is one whose efforts sustain his necessities, fulfill his innate need for service and is yet adventuresome. Such as individual can continually draw consumate strength and eternal youth from such a vocation.

These reasons may explain why physicians commonly are young of heart and their thoughts and deeds frequently belie the calendar.

An ego so nourished blends together energy and compassion, those qualities of human existence that distinguish one from another.

Such a group has built in the cause and need for perpetuation. What is good is best if shared. What is rewarding is most satisfying when extended to others.

No one generation is supposed to be the end product of all that has gone before. Our distance was achieved because of earlier benefactors.

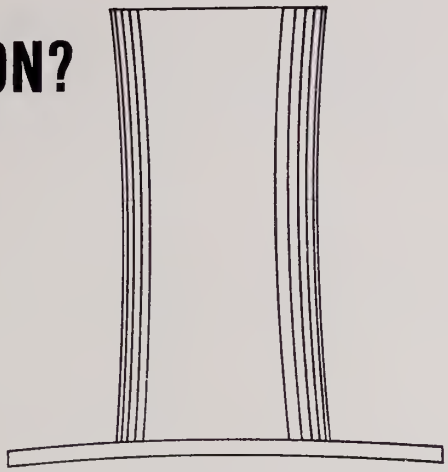
We must now be responsible in return so that our exhileration by the heights will be the stimulus to the next generation so that they too may soar.

HOYT GARDNER, M.D.**

Chairman, KMA Senior Day Committee

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Height and width of this hat are equal, but the unbroken height of the crown appears greater than the interrupted width of the brim. Don't play games with your eyes. Some glasses are poorly crafted. Rely on Southern Optical accuracy.



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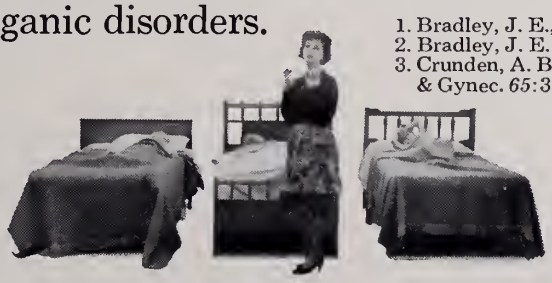
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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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ORGANIZATION SECTION

KMA's 18th Interim Meeting April 19 and 20 at Ken-Bar Inn To Present Five Nationally Recognized Authorities

Five outstanding speakers will be featured in a stimulating program for the 18th. Annual KMA Interim Meeting, April 19 and 20, at Ken-Bar Inn in the Kentucky Dam State Park area at Gilbertsville, Robert E. Pennington, M.D., KMA president has announced. Special reservation forms at Ken-Bar Inn, Doctor Pennington said, would be mailed with the February KMA "Communicator". No deposit will be required with the reservation, but unless notified, reservations will not be held after 6 P.M.



Mr. Shuman

The Fourth Semi-Annual KMA New Member Orientation Program will be held the afternoon of April 19, at the Ken-Bar Inn. The KMA Board of Trustees will also hold a meeting in connection with the Interim Meeting.

The Interim Meeting will open with a dinner, Wednesday April 19, featuring guest speaker, Mr. Charles B. Shuman, president of the American Farm Bureau Federation, whose subject will be "We Are Winning".

Featured speakers for the Thursday morning session are Paul I. Hoagland, M.D., Pasadena, California, William J. Lewis, M.D., Dayton, Ohio, whose subject is "Working to Win", Doctor Joseph Volker, Vice President of the University of Alabama Medical Center, Birmingham, and F. J. L. Blasingame, M.D., executive vice-president of the AMA, who will speak on "A Profession United", at the luncheon session which will close the meeting.

Mr. Shuman, Farm Bureau president, was elected to the Illinois Agricultural Association Board of Directors in 1941 and was named president of the IAA in 1946. He was elected to the American Farm Bureau Federation Board of Directors in 1945 and to the presidency of the AFBF in December of 1954. Mr. Shuman graduated from the University of Illinois College of Agriculture in 1928, and received his masters in agronomy from the state university in 1929.

William J. Lewis, M.D., a Dayton general practitioner, who has a distinguished record in Ohio political action, was elected president of the Montgomery County (Ohio) Medical Society and is now serving as the Society's 118th president. Doctor Lewis graduated from Indiana University School of Medicine in 1951 and completed his internship at Milwaukee County Hospital in 1952. He is a veteran of World War II and is active in Community Chest and YMCA work in Dayton.



Dr. Lewis

It was pointed out by President Pennington that in making the decision to hold the Interim Meeting in the Park Area at this time, the members of the KMA Board of Trustees felt that members of KMA attending the meeting would want to take advantage of the park facilities at Kentucky Dam and enjoy fishing, golfing and other sports in the long weekend following the meeting.

All Kentucky Physicians Must Renew License by March 1

The first annual registration of Kentucky physicians will get underway early in February, according to the Division of Medical Licensure, State Department of Health. The Division hopes to complete the registration on or before March 1.

The policy of having annual registration for physicians in Kentucky was approved at the 1966 meeting of the KMA House of Delegates after refusing to do so twice in recent years. Several KMA committees had supported such action for several years.

The State Board of Health authorized the new annual registration, which will be without registration fee, as provided under Kentucky Revised Statutes 311.565 and 311.600. The regulation applies to all physicians and osteopaths licensed to practice in Kentucky.

Some KMA leaders said such a registration was long over-due because of the need for adequate information on the whereabouts of physicians and the ineffective procedures that have been available for obtaining this information.



Ken-Bar Inn, scene of the 18th, Annual KMA Interim Meeting, April 19 and 20, as viewed from the air. Facilities of this new resort are well suited to house the Interim Meeting and include a meeting room that will seat 450 at a food function.

This is of Interest To You

Confidential Fee Survey

Since our last report in the December issue of The Journal, survey planning and implementation meetings have been held on January 6, 12 and 18.

On January 18, the newly appointed Advisory Committee for KMA Fee Survey held its first meeting at the Association office. With the most unfortunate passing of Doctor Louis Foltz, the original chairman, I agreed to accept this responsibility three days before our January 18 meeting. Each major specialty of the medical profession is represented on this committee, and a large majority of committee members were present. Representatives of Kentucky Blue Shield and the State Department of Health were also present at the meeting, and much was accomplished.

You will recall that the KMA House of Delegates at its September 21 meeting requested the Blue Shield and the State Department of Health to conduct this survey. The reason for this is that the State Department of Health must have creditable statistical data in order to establish predictability of budget costs. The state has agreed to pay half the cost of conducting the survey (up to $20,000). Without this information, there is little chance that the Health Department could implement a usual and customary fee system prior to 1975, which is the deadline required by law.

Mr. Evan Ray, director of the Office of Medical Assistance, and several members of his staff have been meeting with Blue Shield staff and our KMA staff in an effort to develop a survey booklet, which will mutually serve the best interest of all parties involved.

The KMA is eager to substantiate physicians' usual and customary fees so that the State Department of Health can use this method in compensating physicians for services rendered to eligible recipients under this governmental program. In addition, KMA needs this information to negotiate a similar schedule for the expanded program of medical care for dependents of active members of the Armed Forces.

Blue Shield is interested in assisting the medical profession in the acquisition and analysis of this fee information. Blue Shield also needs this information to meet the demands from large purchasers of health care protection for medical and surgical benefit programs to be paid on a usual and customary fee basis.

Both KMA and AMA support the principle of the payment of professional fees on a usual and customary fee basis. If Kentucky physicians ever expect their fees to be paid in this manner, then mass participation in the survey as proposed by Resolution A is essential to the development of such programs by Blue Shield and the Department of Health.

Active participation in the survey by at least 75% of Kentucky physicians would correctly establish usual and customary fees throughout the state rather than have them non-professionally determined.

The proposed survey booklet was reviewed by the Advisory Committee and minor changes were recommended.

It is imperative that the survey booklets be returned to Blue Shield by March 3rd. Your full and prompt cooperation is most essential. The following time table takes into consideration the vast amount of staff work, data processing and other efforts including supervision by our committee which must occur between March 3 and the May 1 deadline.

1. February 17—Blue Shield to mail survey book-

lets to physicians and oral surgeons

2. March 3—Survey booklets to be returned to Blue Shield

3. March 15—Meeting of Advisory Committee for KMA Fee Survey

4. April 18—Meeting of Advisory Committee for KMA Fee Survey

5. May 1—Project completion date

By necessity, the expenditure of money to finance the state's share in the fee survey will require that a contract be drawn up between the Department of Health and Blue Shield. The contract will stipulate what statistical information will be provided and the anticipated date of delivery. The Advisory Committee will be asked to approve its contents.

Mr. Ray and other Health Department officials have given their assurance that all fee information supplied them will be labeled highly confidential and kept in locked compartments.

**This report prepared by Roy H. Moore, M.D., Louisville, chairman of the Advisory Committee for KMA Fee Survey.*

8th KMA Trustee District Meeting Set, March 2

KMA president, Robert E. Pennington, M.D., London, will be the featured speaker at the annual meeting of the Eighth KMA Trustee District.

According to Leroy D. Hess, M.D., trustee, Florence, the Eighth District Meeting will be held at Holiday Inn South, Interstate 75 and the Dixie Highway, on Thursday, March 2.

Doctor Hess indicated that wives would be invited to meet and that each member would receive a personal invitation from him, giving full details.

Dr. Foltz, Louisville Psychiatrist Victim of Heart Attack

Louis M. Foltz, M.D., recent past president of the Jefferson County Medical Society, and long active in psychiatric circles throughout the state, passed away January 15 after suffering a heart attack.

A native of Covington and a graduate of the Eclectic Medical College in Cincinnati in 1937, he took his intership at Speers Hospital in Dayton. During the latter part of his psychiatric residency, he entered the armed forces, where he finished his training.

He was chairman of the Kentucky Commission on Alcoholism, past president of the Kentucky Psychiatric Association.

At the time of his passing, he was chairman of the KMA Advisory Committee for Fee Survey and serving on the KMA Committee to Study Health Services in Kentucky.

Dr. Brockman's Vietnam Trip Featured on Two TV Programs

George F. Brockman, M.D., Greenville, KMA president-elect, was featured on a WAVE TV News Special, January 18, filmed during his second tour of duty in South Vietnam with the Volunteer Physician Program, which is being sponsored by the AMA and the U.S. State Department. The half-hour color program entitled "Kentucky Doctor in Vietnam", was filmed by WAVE newsmen, who met Doctor Brockman by chance while they were on assignment in Vietnam. The film records Doctor Brockman's visit to the city of Tan AN in the Mekong Delta, and shows the health problems of the Vietnamese civilian population.



Dr. Brockman

Doctor Brockman narrated a tour of a Vietnamese hospital, which included the pediatrics ward and newly acquired x-ray equipment, among other things. Doctor Brockman also talked with other American doctors working in the hospital at Tan An.

In the film, Doctor Brockman pointed out that the greatest problems faced by American physicians are the scarcity of equipment, the lack of available medical personnel and medical schools, the prevalence of disease, and poor hygenic conditions in most Vietnamese communities.

The WAVE Special was Doctor Brockman's second television appearance in recent weeks. On December 19, Doctor Brockman appeared on the nationally telecast NBC television program, the "Today" show. He discussed his trip to Vietnam and the Volunteer Physician Program.

Dr. McBeath To Head Heart, Cancer and Stroke Study

William H. McBeath, M.D., formerly the director of the Division of Medical Care in the State Department of Health, has resigned to become the medical director for The Ohio Valley Regional Medical Program.

The medical schools of the Universities of Louisville, Kentucky, and Cincinnati have combined to set up what is known as "The Ohio Valley Regional Medical Program" for the implementation of the heart, cancer, and stroke program sometimes referred to as PL 89-239.

The regional program has received $346,760 from the U.S. Public Health Service to support the first year of a 24-month planning effort.

Southern Ohio, Indiana and most of Kentucky are the areas that will benefit the greatest from this program.

Pediatricians to Meet April 3-5

About 3,000 pediatricians are expected to attend the Annual Spring Meeting of the American Academy of Pediatrics in San Francisco April 3-5 in the San Francisco Hilton Hotel.

Dr. Blankenship, New Ky. Deputy Commissioner of Health

Charles F. Blankenship, M.D., Louisville, Professor and Chairman of the Department of Community Health of the University of Louisville School of Medicine, since 1961, has resigned his post with the University to become Deputy Commissioner of Health for the State of Kentucky.



Dr. Blankenship

Doctor Blankenship graduated from the University of Louisville School of Medicine in 1932 and received his internship training at the U.S. Marine Hospital on Ellis Island, New York. Proir to assuming his position with the University, he served with the U.S. Public Health Service from 1935-1961.

Doctor Blankenship has had numerous articles published in various journals, and as a member of KMA, has been active on various Association committees.

AMA Enlists Volunteer Doctors For Vietnam Program

The AMA, in cooperation with the U. S. State Department, is actively enlisting AMA Volunteer Physicians (formerly Project Vietnam), a program through which American physicians can volunteer for 60-day tours of service at Vietnamese civilian hospitals. The need for physicians to care for the civilian population in Vietnam is great, due to the war and the local shortage of available physicians.

There are approximately 200 or 300 South Vietnamese physicians to care for 16 million civilians. The AMA has requested support for the volunteer program from all fifty states, since a quota of 24 to 32 physician volunteers a month is required to keep 16 provincial hospitals staffed.

George F. Brockman, M.D., Greenville, president-elect of KMA, has completed his second tour of duty in Vietnam with the Volunteer Physicians Program.

SSA To Study Hospital Based MDs

The Social Security Administration has engaged the Columbia University School of Public Health and Administrative Medicine to study the extent of changes that may have occurred in the relationship between hospital-based physicians and hospitals since Medicare was enacted. The study should provide information needed to evaluate Medicare policies and to serve as a basis for administrative and legislative planning.

Occupational Health Conference To Be April 6, Lexington

The Third Governor's Occupational Health Conference will be held on April 6 at the Phoenix Hotel in Lexington. The conference program plans, announced by Charles F. Blankenship, M.D., Louisville, Program Chairman, include outstanding speakers in the occupational health field, from throughout the nation.

The theme of the day-long meeting is, "Management's Role in Occupational Health and Safety". The Chairman of the Conference is Mr. Tom Smith, Associated Industries of Kentucky, Louisville, and Mr. Harry Hoe, Vice-President of J. R. Hoe and Sons, Middlesboro, Kentucky, will serve as Master of Ceremonies for the program.

The guest speakers include, Mr. G. S. Peppiatt, Chairman of the Board of the National Association of Manufacturers, Detroit, Michigan, Keynote Speaker of the program: George M. Wilkering, Chief, Industrial Hygiene and Safety, Bell Telephone Laboratories, Maryhill, New Jersey; Robert B. O'Conner, M.D., Vice-President, Health Services, U.S. Steel Corporation, Pittsburgh; Mr. George A. Jacoby, Director of Personnel Relations, General Mortors Corporation, Detroit; Marion Pearsall, Ph.D., Professor, Department of Behavorial Science, University of Kentucky; Miss Jane Lee, R.N., Occupational Health Nurse Consultant, Division of Occupational Health, U.S. Public Health Service, Washington, D.C., and Wliliam K. Keller, M.D., Chairman and Professor, Department of Psychiatry, University of Louisville School of Medicine.

Walter L. O'Nan, M.D., Henderson, chairman of the KMA Committee whose interest includes industrial health, said the Association is cooperating with the presentation of this conference.

Eradication of Measles is Goal of SDH & KMA Campaign

The KMA is assisting the State Department of Health in its efforts to eradicate measles in the Commonwealth of Kentucky during the campaign that will be carried on in February or March. According to Russell E. Teague, M.D., commissioner of health, the 21 deaths, for example, in 1964 that were due to measles can now be prevented.

Doctor Teague said private physicians in Kentucky are being alerted to the availability of the new dramatic vaccine and he felt confident that with the cooperation of our citizenry our campaign will be successful.

He went on to say the "vaccine is available". Twenty thousand supplemental doses are on hand in this state for use in the community wide eradication campaign scheduled during February and March.

"A state-wide awareness campaign is being commenced to alert parents to the seriousness of the disease, and the availability of protection."





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You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

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Sited for outstanding service to organized medicine are, second from left, O. L. Higdon, M.D., J. Vernon Pace, M.D., center, and Robert W. Robertson, M.D., second from right, at the December meeting of the McCracken County Medical Society. Far left is Frank B. Crawford, M.D., secretary of the society, and far right is Walter R. Johnson, Jr., M.D., all from Paducah.

McCracken Co. Soc. Honors Three Outstanding Drs.

A past KMA president and two former members of the KMA Board of Trustees who are members of the McCraken County Medical Society were honored by their colleagues at a special year-end meeting of their society.

Robert W. Robertson, M.D., J. Vernon Pace, M.D., and O. Leon Higdon, M.D., received citations for "outstanding service to the society as well as to state and national medical organizations."

Doctor Robertson served as KMA president in 1958-1959, as KMA vice president in 1946-1947. He is a charter member and still serving on the board of the Kentucky Physicians Mutual and was a member of the State Board of Health from 1948 to 1964.

Doctor Pace served as KMA trustee for the First District from 1948 through 1959 and was chairman of the board in 1956. He, too, is a charter member of the Board of Directors of Kentucky Physicians Mutual, and served as its chairman in 1959 and 1960. Doctor Pace was also an alternate delegate from KMA to the AMA in 1960 and 1961 and was a delegate to the AMA in 1962 and 1963.

Doctor Higdon has served as the delegate from McCracken County to the KMA, and was vice president of the KMA in 1956. He was an alternate delegate from KMA to the AMA in 1954 and 1955.

He served as trustee from the First District from 1962 to 1965. He was a member of the State Board of Health from 1962 through 1966 and served as its chairman in 1965 and 1966. He was a Fellow of the American College of Obstetrics and Gynecology.

KMA Senior Day Programs Present Top Flight Speakers

Milford O. Rouse, M.D., AMA President Elect and Doctor Thomas Haggai, a nationally famous minister, will be featured on the two KMA Senior Day programs for 1967, Hoyt D. Gardner, M.D., Louisville, KMA Senior Day Committee Chairman has announced.

Doctor Haggai will speak at the program for the U of L seniors March 20 and Doctor Rouse at the U of K program April 11. Each afternoon session will be highlighted by a carefully planned session presented by KMA members.

Doctor Gardner emphasized full appreciation that his Committee and members of the KMA official family have for the cooperation of the two medical schools and the invaluable support of the Jefferson and Fayettee County medical societies in making these programs possible. This is the fourth such program for the U of K seniors and the thirteenth for U of L seniors.

Purpose of the programs is to help the senior medical students to bridge the gap between academic and the actual practice of medicine.

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1967 Annual Meeting — Kentucky Medical Association

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Committee on Scientific Exhibits

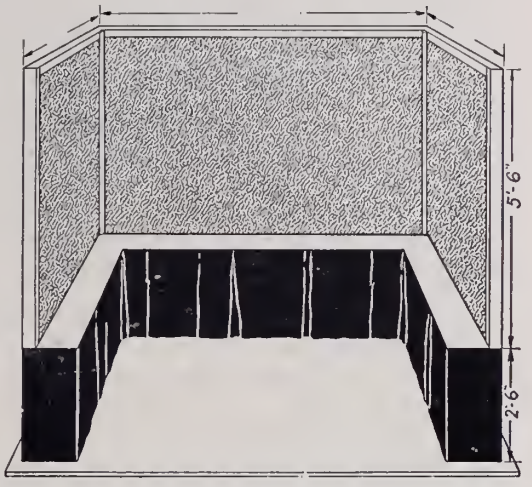
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Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



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4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall ..... Side walls (All side walls are 4') .....
   Square feet needed? ..... Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Mead Johnson Aesculapius Award of $200.00 and identifying plaque will be presented by the KMA for the best exhibit in 1967.

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



Testimonial presentation to Wyatt Norvell, M.D., New Castle, in recognition of his contribution to Kentucky Medicine. From right to left, are Wyatt Norvell, M.D., J. Duffy Hancock, M.D., Woodford B. Troutman, M.D., Ludwig H. Segerberg, M.D., Roy A. Martin, M.D., Henry B. Asman, M.D., all of Louisville, John I. Cooper, M.D., Bedford, Charles O. Bruce, Jr., M.D., Louisville, and lower left, John B. Trawick, Jr., M.D., Louisville.

30th New Orleans Assembly

The 30th. Annual Meeting of the New Orleans Graduate Medical Assembly has been scheduled for March 6-9, 1967, at the Roosevelt Hotel in New Orleans. There will be nineteen guest speakers representing various fields of medicine. The registration fee of $25 covers the lectures, medical motion pictures, symposia, a clinicopathologic conference, technical exhibits, three round-table luncheons, and other features. The program will be acceptable for 30½ credit hours by the American Academy of General Practice.

Med. Libraries Compile Serial List

The University of Louisville School of Medicine Library, in cooperation with sixteen hospitals in the Louisville area, has recently published "The Union List of Serials" of the medical libraries in the Metropolitan area in 1966. The project, a listing of all available medical journals in the area, was undertaken by Mrs. Frances Livingston, Senior Librarian for Technical Services. All libraries involved helped to finance the project.

This list, which will be brought up to date periodically, is the first attempt at a plan of cooperation between medical libraries throughout the state. Joan Titley, Librarian at the University of Louisville Medical Library states: "Such lists provide the key to the vast store of medical knowledge that is housed in the several thousand currently produced medical journals".

Disseminated Histoplasmosis

(Continued from Page 155)

nervous system and adrenal glands.

Histoplasmosis organisms were seen on bone marrow smears. Bone marrow, blood and spinal fluid all grew out pure cultures of histoplasma capsulata.

The patient received twelve days of amphotericin B treatment in adequate amounts without apparent toxic effect. No clinical improvement was observed and the patient died.

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KMA Announces Co. Med. Soc. Officers for 1967

KMA Headquarters Office has received, as of January 20, the following reports of County Medical Officers and Delegates for 1967:

Ballard
President: Glenn Baird, M.D., Bandana
Secretary: J. M. Hunt, Jr., M.D., Wickliffe
Delegate to KMA: Glenn Baird, M.D.
Alternate: J. M. Hunt, Jr., M.D.

Bourbon
President: James E. Johnson, Jr., M.D.
Vice-President: William S. Morgan, M.D., Paris
Secretary-Treasurer: Harry Galloway, M.D., Paris
Delegate to KMA: James Ferrell, M.D., Paris
Alternate: William Cox, M.D., Paris

Bullitt
President: W. B. Hamilton, M.D., Shepherdsville
Vice-President: S. T. Hanover, M.D., Shepherdsville
Secretary: Patrick Murphy, M.D., Lebanon
Delegate to KMA: John R. Gleason, M.D., Shepherdsville
Alternate: W. B. Hamilton, M.D.

Clinton
President: Earnest A. Barnes, M.D., Albany
Secretary: Floyd B. Hay, M.D., Albany
Delegate to KMA: Earnest A. Barnes, M.D.
Alternate: Floyd B. Hay, M.D.

Fleming
President: W. A. Graham, M.D., Flemingsburg
Vice-President: Samuel W. Gehring, M.D., Flemingsburg
Secretary: Benjamin F. Allen, M.D., Flemingsburg
Delegate to KMA: Samuel W. Gehring, M.D.
Alternate: R. W. Fidler, M.D., Flemingsburg

Green
President: G. L. Cheatham, M.D., Greensburg
President-Elect: J. W. Miller, M.D., Greensburg
Secretary-Treasurer: K. Y. S. DeSimone, M.D.
Delegate to KMA: G. L. Cheatham, M.D.
Alternate: R. Simmons, M.D., Greensburg

Harrison
President: Joe A. Nichols, M.D.
Vice-President: Henry H. Moody, M.D., Cynthiana
Secretary: Don Stephens, M.D., Berry
Delegate to KMA: Henry H. Moody, M.D.

Hickman
President: C. J. Mills, M.D., Clinton
Secretary: H. E. Titsworth, M.D., Clinton
Delegate to KMA: C. J. Mills, M.D.

Knox
President: T. R. Davies, M.D., Barbourville
Vice-President: R. E. Hayden, M.D.
Secretary-Treasurer: H. L. Bushey, M.D.
Delegate to KMA: H. L. Bushey, M.D.
Alternate: F. X. Sommer, M.D., Barbourville

Lincoln
President: H. I. Frisbie, M.D., Stanford
Vice-President: T. S. Wright, M.D., Stanford
Secretary-Treasurer: Edward C. Bowling, M.D.
Delegate to KMA: H. I. Frisbie, M.D.
Alternate: Edward C. Bowling, M.D.

Madison
President: Arch Clark, M.D.
Vice-President: William Clouse, M.D., Richmond
Secretary: Max Blue, M.D., Richmond
Delegates to KMA: William Epling, M.D., Berea
Ralph Bowling, M.D., Richmond
Alternates: John Wimberly, M.D., Bowling Green
Hugh Mahaffey, M.D., Richmond

Mercer
President: J. M. Keightley, M.D., Harrodsburg
Vice-President: J. S. Baughman, III, M.D.
Secretary: (Re-elected) C. B. VanArsdall, Jr., M.D., Harrodsburg
Alternate: C. B. VanArsdall, M.D.

Owsley
President: John R. Aker, M.D., Booneville
Secretary-Treasurer: M. D. Gabbard, M.D., Booneville
Delegate to KMA: M. D. Gabbard, M.D.

Rowan
President: J. Hunter Black, M.D., Morehead
Vice-President: Warren H. Proudfoot, M.D., Morehead
Secretary-Treasurer: B. J. Caudill, M.D.
Alternate: Everett Blair, M.D., Morehead

Trimble
President: John I. Cooper, M.D., Bedford
Secretary: Carl Cooper, M.D., Bedford
Delegate to KMA: Carl Cooper, M.D.
Alternate: John I. Cooper, M.D.

Whitley
President: Billy H. Wells, M.D., Corbin
Vice-President: Gene W. Scott, M.D., Williamsburg
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Alternate: Roemer D. Pitman, M.D., Williamsburg

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KMA Board of Trustees

Digest of Proceedings

December 7 and 8, 1966

President's Report

The President's Report highlighted the many activities that the President had carried on in behalf of the Association, in the past three months.

Report of the Delegates to the AMA

The report of the Delegates to the AMA Clinical Meeting in Las Vegas late in November was moderated by our Senior Delegate, J. Thomas Giannini, M.D. Each of the Delegates and the other members of the Board who had worked reference committees at the Las Vegas meeting reported on material covered by reference committees assigned to them.

Report of the Secretary

Henry B. Asman, M.D., secretary, gave the Headquarters Office Report. It was indicated that the staff had worked 22 meetings of committees and councils, 18 meetings of related interest and 7 out-of-state meetings since Annual Session.

Report of the Committee to Study Health Services in Kentucky

The Board of Trustees, having been concerned about fragmentation of health services in Kentucky, had appointed a committee earlier in the year chaired by Gabe A. Payne, Jr., M.D. After two meetings of this committee, Doctor Payne explained that in order to quality for funds for this study under PL 89-749, that certain conditions would have to be met. He made the following recommendations that were accepted by the Board.

The first, that the Governor of Kentucky in implementing PL 89-749 designate the Health Department as the administering agent. The second recommendation related to the appointment of the State Health Planning Council, which would be composed of 25 members, a majority of which would be in the "Consumer" group.

The third suggestion related to the use of technical advisory committees from the various providers of service to assist the proposed new council.

Doctor Payne indicated that the committee expected to continue working and his request, that the Board ask The Journal to support communications in this field, was accepted.

Resolution D

There was discussion as to how Resolution D should be implemented. It was felt by some that this resolution, which calls for a state-wide KMA survey commitee for improved community health utilizing study groups from both professional and lay organizations at the committee level, be handed to Doctor Payne's committee for implementation.

Concern was expressed over how much the survey would cost and that no provision had been made in the resolution for its implementation as provided by the recently enacted Bylaws. After full discussion, it was decided that a commitee should be appointed to look into the matter of preparing a cost and feasiability study and to report back to the 1967 House of Delegates.

Nominations for the State Board of Health

In compliance with the Kentucky Revised Statutes, the Board of Trustees nominated three Kentucky physicians for each of the two vacancies that resulted from expiration of terms December 31, on the State Board of Health.

Recommendations from the Council on Legislative Activities

The Board accepted recommendations from the Council on Legislative Activities and agreed to support the Kentucky Farm Bureau and the Louisville Chamber of Commerce on the matter of time change; support the efforts to obtain legislation requiring Immunization Vaccine REH—for measles; resist further attempts in state government to create legislation through a simple appropriation; that all committees and medical groups cooperate in clearing legislative proposals with the KMA Council on Legislative Activities and the authorization of two KMA lobbyists in Frankfort during the Legislature.

Orientation Matter and Plaques for Board Members

A matter relating to the orientation program was disposed of. The proposal for plaques for Board members was indefinitely tabled and the recommendations of the joint KMA-KNA Advisory Committee were approved as amended.

Technical Advisory Committee for Medical Assistance

The Board then considered the reaction to the the November 11 letter distributed by the State Department of Health relating to procedures for receiving payment under the "medicaid program". Several KMA members testified on this matter and Garnett J. Sweeney, M.D., chairman of the KMA Technical Advisory Committee, discussed the matter in detail. After full discussion, the Board took the following action:

RESOLVED that Doctor Sweeney's committee be instructed to inform the Department of Health that the physicians of Kentucky insist upon:

(a) One simple form to submit to the Division of Medical Care or Metropolitan (but *not* both) for payment of their fees for services rendered to government medical care beneficiaries; and

(b) Payment of their usual and customary fees.

RESOLVED further, that the Department be informed that we do not expect action on usual and customary fees until the survey is completed, but that we do expect immediate action on the forms, and that if simplification is not achieved to our satisfaction by January 15, 1967, we will advise our membership that they are not required to accept assignments for their fees from public assistance recipients under Title XIX.

ODMC Matters

The Board next heard the Chairman of the Committee whose responsibility it is to follow the ODMC and VA Hometown Medical Care programs. Recommendations from L. Douglas Atherton, M.D., the chairman of the Committee, relating to expanding of the Review Committee to include general practitioners and delaying the negotiations of the Hometown service-connected medical care program with the VA until after July 1, at which time the usual and customary fee survey was scheduled to be completed, were accepted.

Report from KEMPAC

It was indicated that KEMPAC had 829 members for 1966, which was a new all-time high in Kentucky. Expression of appreciation from the KEMPAC Board to the Board of Trustees was read. The Board of Trustees voted to continue the support of KEMPAC Educational Fund at the same level in 1967 that it had in 1966.

Liability Coverage

The Legal Counsel discussed liability members serving in leadership capacity for the Association might have. The company specializing in this area, which was reported to carry a majority of Kentucky physicians, covers the members for any liability in this area under the clause in its contract which reads: "based on professional services rendered or which should have rendered".

Recommendations of the Council on Medical Services

The Board approved this Council's recommendation that KMA support legislation making the Kentucky Department of Health the sole agency for the administering of the medical assistance program of the aged.

Recommendations of the Council on Governmental Medical Services

The Board approved the recommendation that the "Hoover Commission" study a suggestion which would reportedly prevent overlapping of the duties of certain KMA committees and councils. It was indicated that Resolution H, passed at the 1966 meeting of the House, which called for direct billing under Title XIX of the Social Security Act had been discussed with the appropriate AMA officials and that it was not possible to implement it at this time.

The Board then accepted the recommendation that the Association oppose compensation from governmental sources for services provided by anatomical laboratories that are not under the direct supervision of licensed physicians. A broad statement of the delineation of the duties of each of the committees under the Council was approved.

Recommendations of the Council on Communications and Public Service

The Board approved the recommendation that a careers committee be set up under this Council; that a speakers' bureau which would be publicized to lay organizations be established within the Council, and that the present statewide diabetes detection program be discontinued. Another motion in this area encouraged individual county physicians to carry on the program in cooperation with the State Department of Health.

Miscellaneous Actions

The Board expressed appreciation to the Central Association of Obstetricians and Gynecologists and to the Southern Surgical Association for contributions to the McDowell House; referred a suggestion that the fiscal year of the Association be changed to end September 30 to the "Hoover Commission"; expressed appreciation to Ellis Fuller, M.D., guest editor of the October issue of The Journal of KMA; heard a report from the AMA Board of Trustees by Robert C. Long, M.D.; made changes in the Maternal Mortality Study Committee as requested and agreed to co-sponsor an infection control course at the University of Louisville.

AMA-ERF Loans Curtailed

The general curtailment of loans during the past year has forced two of the three banks in the AMA Educational and Research Foundation Loan Guarantee Program to terminate their agreements to lend money through the program. The AMA-ERF Board of Directors announced the action after their October 28 meeting. Now effective, loans under this program must be limited to $750 per borrower per year. In addition, the interim interest rate will be increased from 6 to 7%.

In the past four and one-half years, the AMA-ERF has made more than 30,000 loans amounting to over $35,000,000. These loans have been made to persons in medical training for living and training expenses. During that time no legitimate request for loan funds has been turned down.

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE

LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK ***"PRAY YOUR WEIGHT AWAY"*** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



DIET DROPOUTS

ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."*

THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:28 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety ...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extenabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

Ambar #2 Extentabs®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming)

BRIEF SUMMARY—**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. See package insert for further details.

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in sinusitis, colds, U. R. I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
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up to 10-12 hours clear breathing on one tablet

It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

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"Yes, Doctor, the pain is gone."

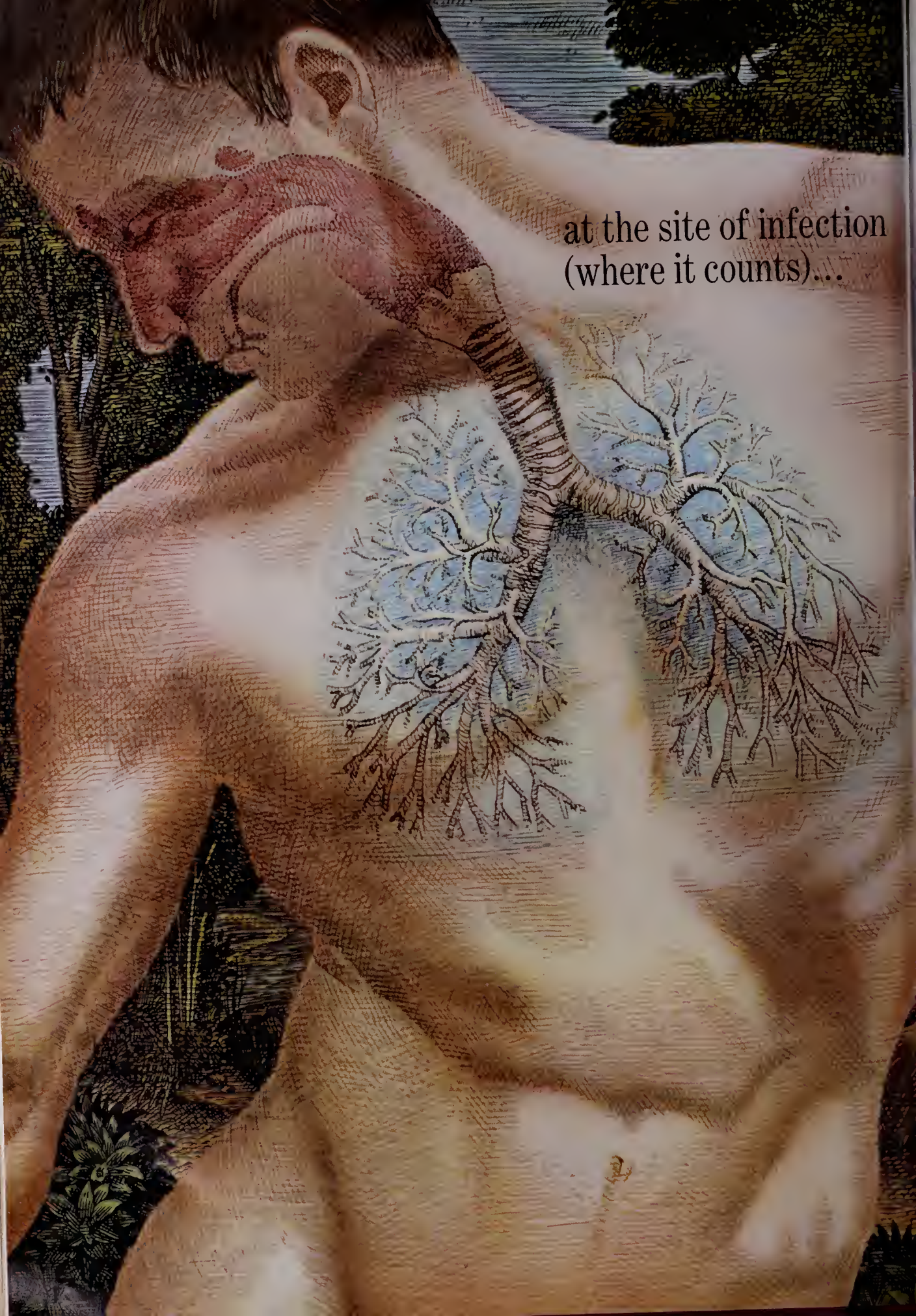
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at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®

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Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, elev alkaline phosphatase levels, negative or weakly positive cepl flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses o medication. Patients with chronic infection have been given to 2 Gm. of the drug daily for periods of two to six months patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one grou 144 patients who received the drug daily for two years, no j dice was noted. It was of interest that members of six of t patients' families, who were not taking the drug, had epi of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children who 250 mg. of Ilosone daily for an average of sixteen montl rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who received icillin. There were no cases of jaundice in either group. Elev of SGPT and serum alkaline phosphatase levels during the c of treatment was observed in one patient treated with Il and in two patients treated with penicillin. Seven other pat in the group receiving Ilosone and four others in the peni group showed elevations in one of the tests at some time du administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus i tions. Results of liver function tests in these patients were parable to those in a similar control group who had rec penicillin.

Gastro-intestinal disturbances not associated with hepat fects are observed in a small proportion of individuals as a r of a local stimulating effect of the medication on the alimer tract; however, the normal intestinal gram-negative bact flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th of erythromycin, there have been occasional reports of urtic skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.
Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hours children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual d of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythro therapy should be considered.

In the treatment of syphilis, the recommended total dos 20 to 30 Gm. given in divided doses for a period of ten to fi days. Close follow-up of the patient is necessary since ery mycin drugs have not had adequate evaluation in all stag syphilis. Examinations of spinal fluid are recommended as a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four day recommended. In the treatment of gonorrhea, patients w suspected lesion of syphilis should have a dark-field examin before receiving antibiotics, and monthly serologic tests s be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25 (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to b in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 1 size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pack

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69,
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398,
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Are You Qualified to Vote May 23?

In order to vote in the May 23 primary you must be properly registered by Saturday, March 25, 1967, according to Fred C. Rainey, M.D., Elizabethtown, chairman of the KMA Council on Legislative Activities for state affairs. Doctor Rainey urged all members, their families and staff to qualify and vote in the May 25 primary.

If there has been any change whatever in your status in the last two years, this matter should be checked, the KMA Chairman said. A new governor, lieutenant governor, all top state officials, 20 senators and 100 representatives will be elected. Many of these offices will be determined in the May 23 primary.

In the Books

(Continued from Page 128)

arthritis, the validity of boards in internal medicine and of statistics in medical research. The editors have added discreet comments summarizing and occasionally refreeing some of the topics.

This is an adult book, intended to lay bare the basis for many clinical actions as presented by proponents of each view. It will be useful for the young clinician lest he fix his habits too soon and for the more experienced, it will provide the necessary degree of challenge to cherished therapeutic enthusiasms. For all, including medical students, it should be a stimulating review of the data on common problems, forcing a reconsideration of ones own opinions, revealing gaps in the evidence, highlighting areas of agreement and indicating possible methods of resolution.

Space does not permit critical analysis of the presentations. As one might expect in a multi-author book, they are uneven in style, objectivity, skill in marshalling the evidence and sticking to the point. Some are too diffuse and too lengthy as they try to resolve all problems. All, however, are competently done and worth reading. The book could be improved by tighter editing. The controversies could be better sharpened by the proposal and rebuttal method instead of the method of a statement without prior knowledge of what the opposing author would say.

Nonetheless, the book does an important service. The art of spirited controversy in the interest of truth has fallen into a bad state in a society in which even scientific conformism is dangerously evident. Its sophisticated revival is essential for the physicians intellectual health and more importantly for his patients welfare. While the book can be improved, this reviewer applauds the editors effort to stimulate adult controversy and hopes they will extend the effort into other areas.

E. D. Pellegrino, M.D.

APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, Vol. 3: edited by John Adriani, M.D.; Published by the C. V. Mosby Company, St. Louis, 1966; 522 Pages; Price, $10.85.

The busy clinician in every specialty is always struggling to keep abreast of new developments in medical science but books and journals seem to pile up faster than he can read them. When he does have time for study he finds controversy on every hand, and often becomes more confused than when he started. Anesthesiologists in this predicament may feel their prayers are answered when they see the respected name of John Adriani as editor of a volume called *Appraisal of Current Concepts in Anesthesiology* but they are in line for a rude disappointment.

Instead of finding a critical appraisal of current ideas by a recognized authority, they will find a collection of 150 papers written as class exercises by Dr. Adriani's residents and junior staff, each of whom was apparently assigned a topic and instructed to review the literature and write a brief summary of the subjects. With little visable editing, Dr. Adriani then assembled the papers as chapters of this book.

About the best that can be said of these papers is that they are mercifully brief, but unfortunately the brevity extends to the bibliography of most of the chapters so that they serve as a poor basis for further study. For example, the chapter on maternal physiologic changes in pregnancy cites only two references, and one of these is to a 1957 textbook—hardly a thorough review of current work.

The emphasis on brevity may also account for another weakness common to a great many chapters, namely, the manner in which controversial subjects are handled. Some of the contributors approach the problem by pretending there is only one side to the matter, and ignore any mention of controversy. Other contributors take care of this dilemma by citing literature on one side of the subject in the body of their paper and then draw an opposite conclusion in their chapter summary. Neither approach can be called a critical appraisal of current thinking.

The book also plagues the reader with numerous spelling and grammatical errors, and the last chapter presents the sorry spectacle of over thirty pages where virtually every paragraph begins with the word "note".

This collection of class exercises should have received the teacher's red pencil rather than a publisher's green light. They certainly do not merit the attention of the practicing anesthesiologist.

Donald M. Thomas, M.D.

Retail Druggists Support H.R. 276

The National Association of Retail Druggists has announced its active support of the Boggs Bill (H.R. 276) which has been introduced into the 90th Congress.

The purpose of this Bill is to amend Title XVIII, Part B, of PL 89-97 to enable the physician and the pharmacist to provide prescription drugs for Medicare recipients.



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

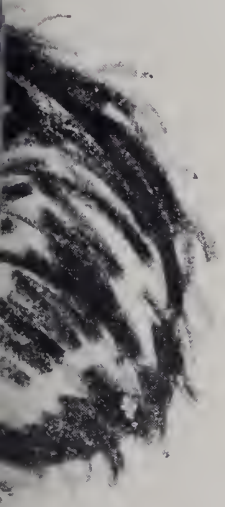
Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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Neo-Synalar®
(fluocinolone acetonide-neomycin sulfate cream)
Cream

The "itch-scratch" cycle usually associated with inflammation often results in infected dermatoses because broken skin surfaces are particularly vulnerable to pathogenic bacteria.[1] To treat infected inflammatory dermatoses, Neo-Synalar Cream combines the most active topical corticosteroid with a highly reliable antibiotic generally reserved for topical application.

In Neo-Synalar, fluocinoline acetonide controls the inflammation and provides rapid relief from associated pruritus. At the same time, its antibacterial component—neomycin—combats superficial infection caused by many gram-positive and gram-negative bacilli[2] that often colonize and thrive on abraded skin.[1]

A specially formulated vanishing cream base that is greaseless and odor free makes Neo-Synalar cosmetically appealing, and encourages greater patient cooperation.

controls the infection

stops the scratch

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Neomycin rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Neo-Synalar under certain conditions. **Availability:** Neo-Synalar Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. **2.** Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

Dr. Keller Named by LBJ To Serve on Motor Advisory Council

William K. Keller, M.D., professor and chairman of the department of psychiatry, University of Louisville School of Medicine has been appointed to the National Motor Vehicle Advisory Council for President Johnson.

He was one of seventeen named to serve on the council, which is composed of the members from the public and the automotive industry.* Purpose of the council, according to published reports is to study the controversial federal safety standards for the automobile manufacturers. It held its first meeting January 19.

(*Doctor Keller has long had an avid interest in this field and is presently the chairman of the KMA Highway Safety Committee.)

Knox County Honors Dr. Davies For 32 Years Services as Secretary

Theodore R. Davies, M.D. Barbourville, concluded thirty-two years of service to the Knox County Medical Society and the KMA as secretary of the Knox County group.

At the December meeting of the county society, Doctor Davies was made president. A graduate of 1931 of the University of Louisville School of Medicine, Doctor Davies has served on a number of occasions as delegate to the KMA, has been an active member of several of KMA's committees and is currently serving as a member of the local board of health.

Members of the Knox County Medical Society praised the long and effective work of Doctor Davies to his profession at the time he was unanimously chosen to serve as the group's president.

Military Dependents Program Expanded and Renamed

As a result of expanded benefits enacted late in the 89th. Congress providing for dependents of active members of the Armed Forces, the name of the program has been changed from ODMC (Office of Dependents Medical Care) to CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

The amendments to the original law provided two significant changes. First, expanding outpatient benefits; and second, the payment of physicians' fees on a usual and customary basis.

On outpatient services, the new program provides there will be a $50 deductible on an individual basis and $100 of a family with the patient paying the deductible.

On the remaining charges, the government pays 80 per cent with the patient paying 20 per cent, thus utilizing the familiar co-insurance approach.

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MARGARET KELLY, R. N., Director of Nurses

KMA Announces Five New Members

Five physicians have become new members of the Kentucky Medical Association, according to the records of the membership department. The following are the new members of KMA, as of January 20:

C. M. Steinfeld, M.D., Providence, Frank S. Cascio, M.D., Lexington, Francine Middelman, M.D., Lexington, John Dixon Perrine, M.D., Lexington, and J. Kent Trinkle, M.D., Lexington.

Dr. Shepard Heads Radiologists

Robert Shepard, M.D., Lexington, will assume office as president of the Kentucky Chapter, American College of Radiology, on March 1. Harold Davis, M.D., Louisville, was chosen president-elect at the Chapter's September meeting in Louisville. Other officers are: J. T. Ling, M.D., Louisville, Secretary-Treasurer, Frank Becktel, M.D., Louisville, Councilor, and LeRoy Boswell, M.D., Lexington, Assistant Councilor.

COUNTY SOCIETY REPORTS

McCracken

The regular meeting of the McCracken County Medical Society was held at Boswell's Restaurant on the night of December 21, 1966.

In the business meeting held at this time, the following county officers were elected:

President	Walter Johnson, M.D.
Vice President	Rex Holland, M.D.
Secretary-Treasurer	William Smith, M.D.
Executive Committee	Joe Spaulding, M.D.
	O. D. Maxey, M.D.
Board of Censors	Walker Turner, M.D.
Delegate	James Embry, M.D.
Alternate Delegate	George Widener, M.D.

Announcement was made of KMA's First Trustee District meeting, in Paducah, January 25, and other routine affairs were handled.

Special emphasis was given to KMA's Interim Meeting at the Ken-Bar Inn, Gilbertsville, April 19 and 20.

Treatment of Pain Related to Cancer

(Continued From Page—)

21. Petrie, A.: *Some Psychological Aspects of Pain and the Relief of Suffering.* Ann. N.Y. Acad. Sci., 86:13-26, 1960.
22. Rosomoff, H., Carroll, F., Brown, J., and Sheptak, P.: *Percutaneous Radiofrequency Cervical Cordotomy: Technique.* J. Neurosurg., 23:639-644, 1965.
23. Spiller, W. G., and Martin, E.: *The Treatment of Persistent Pain of Organic Origin in the Lower Part of the Body by Division of the Anterolateral Column of the Spinal Cord.* J. Amer. Med. Assn., 58:1489-1490, 1912.
24. Stewart, W. A., and Lourie, H.: *An Experimental Evaluation of the Effects of Subarachnoid Injection of Phenol-Pantopaque in Cats. A Histological Study.* J. Neurosurg., 20: 64-72, 1963.
25. Turnbull, Frank: *The Nature of Pain in the Late Stages of Cancer.* Surg., Gynec., & Obst., 110:665-668, 1960.
26. White, James C.: *Choice of Surgical Procedures for Relief of Pain in Incurable Diseases of Chest and Abdomen.* Surg. Clin. N. Amer., 38:1373-1392, 1958.
27. Woodhall, B., Mahaley, S., Jr., Boone, S., and Huneycutt, H.: *The Effect of Chemotherapeutic Agents Upon Peripheral Nerves,* J. Surg. Res., 2:373-379, 1962.

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KMA Council and Committee Reports

Committee on Cults

David B. Stevens, M.D., Chairman

KMA Headquarters Office **November 14, 1966**

The KMA Committee on Cults met on November 14 to review past activities and to make plans for the coming associational year.

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **December 22, 1966**

At their first meeting for this associational year, the committee members reviewed the major items of interest from last year to include administrative relationships between hospitals and private practitioners of medicine practicing within hospitals, and area-wide hospital planning. In addition, continuing interest is being maintained in matters involving hospital based specialists and a recommendation is being made to the KMA Board of Trustees that Kentucky radiologists be polled to determine their billing preference.

Continued discussion centered on area wide hospital planning and the activities of the committee's "Dry Run" hospital accreditation teams which are being enlarged.

Fees for house officers and other salaried physicians were discussed in detail and a recommendation concerning this subject was approved for trasmittal to the Board of Trustees. The committee's next meeting was scheduled for May 11, 1967.

Council on Medical Education and Hospitals

Walter I. Hume, Jr., M.D., Louisville, Chairman, Presiding

KMA Headquarters Office **December 15, 1966**

At their recent meeting, the members of the Council on Medical Education and Hospitals reviewed the report to the House of Delegates last year as well as the reports of the committees reporting to them, took action on referrals to the council and assigned specific items to the committees serving under the council.

AMA actions at the Annual Meeting in June 1966 and at the Clinical Meeting in November 1966 pertaining to the field of medical education and hospitals were reviewed and discussed in view of the council's interest and responsibility.

It was agreed that items demanding members' attention this year included: PL 89-239 (Heart Disease, Cancer, and Stroke, various reports concerning the planning for the family practitioner, reimbursement of full time salaried physicians, interns and residents and the possible use of educational television in medical education. Adjournment followed the making of plans for future meeting dates of the council and committees. The next council meeting date was scheduled for May 25, 1967.

Disaster Medical Care Committee

William T. Rumage, Jr., M. D., Louisville, Chairman

KMA Headquarters Office **December 29, 1966**

The Disaster Medical Care Committee had a number of guests from allied organizations at its recent meeting and discussed numerous matters requiring the committee's attention in the months ahead.

Plans are being made to conduct a conference on emergency medical services jointly with the Kentucky Hospital Association later in the year. Additionally, it was agreed that a meeting should be held with representatives of government, communications companies, and the Kentucky Hospital Association to initiate planning for an adequate statewide emergency communications system.

Transportation of the injured and the KMA Headquarters Building fallout shelter were among other items receiving attention. The next meeting of the committee will be held during the spring.

Public, Rural, and Occupational Health Committee

Walter L. O'Nan, M.D., Henderson, Chairman, Presiding

KMA Headquarters Office **December 15, 1966**

Under the re-organization approved by the 1966 House of Delegates, this was the first meeting of this committee facing the combined duties formerly held by the Public Health Committee, Rural Health Committee, and Industrial Medicine Committee. The diverse interests interests of these previous committees presented the committee with a full workload for the year for which plans were made.

The committee members noted action taken of the final reports submitted by the above-mentioned committees to the 1966 House of Delegates and took appropriate action on referrals brought to their attention by the KMA Executive Committee.

Plans were made for KMA Immunization Week to be held May 1-6, 1967, and continued support and promotion of Community Health Week was authorized. The next meeting date of the committee was scheduled for March 23, 1967.

Thomas R. Marshall, M.D., Louisville, who headed the Department of Radiology at the University of Louisville School of Medicine, has gone into private practice in Louisville. He is limiting his work to radiology and isotope studies.

NEWS ITEMS

Carl H. Scott, M.D., Lexington, was elected to Fellowship in the American Academy of Pediatrics at a recent meeting in Chicago. Doctor Scott is among 255 pediatricians inducted into Fellowship.

Phillip H. Isacco, M.D. Barren County Health Officer for 14 years, has resigned his post to accept a position in Key West, as medical director for Monroe County, Florida.

Janet M. Boog, M.D., is now associated with the Lexington Veteran's Administration Hospital, limiting her practice to psychiatry. She graduated from the New York Medical College in 1939 and completed her internship at Good Samaritan Hospital, New York, in 1940. She formerly has practiced at New York's Veteran's Administration Hospital, Bellevue Psychiatric Hospital, in New York, and in the states of Massachusets and Michigan.

John W. Armstrong, M.D., Berea, was the recipient of the Man-of-Yesteryear award for 1966 from the Berea Chamber of Commerce.

In Memoriam

BERTIS N. COMER, M.D.
1886-1966
Falmouth, Ky.

Bertis N. Comer, M.D., 80, Falmouth physician died Thursday, December 22, after a brief illness. Doctor Comer, a 1917 graduate of the University of Louisville Medical College, was a veteran of World War I. He had practiced in the Falmouth community for over forty years.

Edith Smith, M.D.
Lexington, Ky.
1875-1966

Edith Smith, M.D., 91, a Lexington surgeon who served at the front lines during World War I, died Monday, December 19, after a long illness. Doctor Smith graduated from the Medical College of Ohio, in Cincinnati, in 1909, and spent the greater part of her professional career in Cincinnati, moving to Lexington after her retirement in 1954.



He leaves to make an urgent call But doesn't use the phone at all

Parepectolin for quick relief of acute diarrhea
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Each fluid ounce of creamy white suspension contains:
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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
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Usual Adult Dose: One or two tablespoonfuls three times daily.

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Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —Pen•Vee® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections due to pathogens susceptible to oral penicillin G. Prophylaxis of rheumatic fever in patients with previous history of the disease.

Precautions: Skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin-allergy may occur. Measures for treating anaphylaxis should be readily available: epinephrine, oxygen and pressor drugs for relief of immediate allergic reactions; antihistamines and corticosteroids for delayed effects. Penicillin may delay or prevent the appearance of primary syphilitic lesions. Patients with gonorrhea who are suspected of concurrent syphilitic infections should be tested serologically for at least 3 months. Where lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. As with other antibiotics overgrowth of nonsusceptible organisms may occur; if so, discontinue and take appropriate measures. Treat β-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Composition: Tablets—125 mg. (200,000 units) and 250 mg., (400,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. **Wyeth Laboratories Philadelphia, Pa.**

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Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
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B and C vitamins aid therapy. Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.



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Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. *Contraindications:* Patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. *Precautions:* Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease; and, in patients who may operate vehicles or machinery, warn of possible drowsiness. *Note:* Since the iodine in isopropamide iodide may alter PBI test results and will suppress i^{131} uptake, it is suggested that 'Ornade' be discontinued one week before these tests. *Side effects:* Drowsiness; excessive dryness of nose, throat, or mouth; nervousness; or insomnia may occur rarely, but are usually mild and transitory. Other known possible side effects of the individual ingredients are: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, and difficulty in urination.

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Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

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From The

KMA Postgraduate Medical Education Office

The Fifth Annual Seminar on "Clinical Problems in the Newborn" will be held at the Good Samaritan Hospital, Cincinnati, Ohio, on April 13. Guest lecturers will include Ivan Diamond, M.D., William Cochrane, M.D., and Joseph Dancis, M.D. Those interested in attending, please contact: Charles V. Pfahler, M.D., Department of Pediatrics, Good Samaritan Hospital, Cincinnati, Ohio 45220.

IN KENTUCKY

MARCH

15-17 Recent Advances in Pediatric Clinical Pathology, University of Kentucky Medical Center, Lexington

23-25 Fifth Annual Postgraduate Seminar for Pediatricicans, University of Kentucky Medical Center, Lexington ($35.00 fee)

APRIL

6 Third Governor's Occupational Health Conference, Lexington

22 Industrial Doctors and Nurses, Executive Inn, Louisville. (All day Meeting)

MAY

1-5 Symposium on "Current Concepts in Chest Radiology: Pathophysiological Correlations," Department of Radiology, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

FEBRUARY

15-19 American College of Cardiology, Washington Hilton Hotel, Washington, D.C.

23-25 American Academy of Pediatrics, Boston Lying-In Hospital, Boston

26-March 4 American Society of Clinical Pathologists, Dunes Hotel, Las Vegas

MARCH

6-9 New Orleans Graduate Medical Assembly, Thirtieth Annual Meeting, Roosevelt Hotel, New Orleans, La. ($25.000 fee)

8-9 Cleveland Clinic Education Foundation, "Advances in Urology," Bunts Auditorium, Cleveland, Ohio

9-11 American Academy of Pediatrics, University of Tennessee College of Medicine, Memphis

10-11 20th. National Conference on Rural Health, Queen Charlotte Hotel, Charlotte, N.C.

10-12 American Association of Pathologists and Bacteriologists, Sheraton Park Hotel, Washington, D.C.

29-30 Cleveland Clinic Educational Foundation, "Medical Progress and its Relationship to Dentistry," Bunts Auditorium, Cleveland

30-April 1 American Academy of Pediatrics, Stanford University of Medicine, Palo Alto, Calif.

APRIL

3-7 40th. Annual Spring Congress in Opthalmology and Otolaryngology, Gill Memorial Ear, Eye and Throat Hospital, Roanoke, Va.

5-6 Cleveland Clinic Educational Foundation, "Diagnosis Procedures in Gastroenterology," Bunts Auditorium, Cleveland

10-13 Industrial Medical Association, Americana Hotel, Bal Harbour, Fla.

13 Fifth Annual Seminar on "Clinical Problems of the Newborn," Good Samaritan Hospital, Cincinnati, Ohio

Plans for Eye Institute Advance

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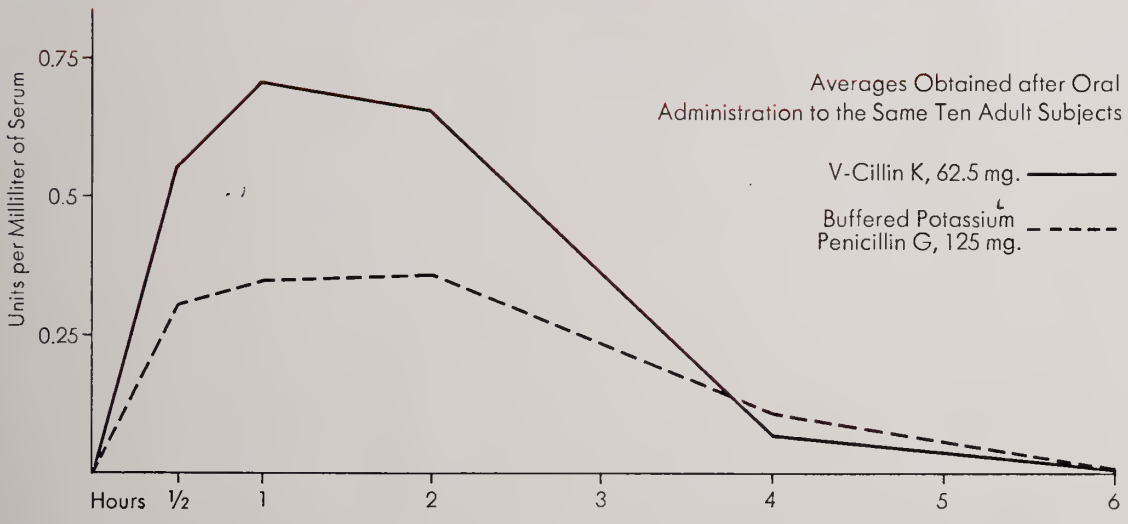
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Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269 1019, 1963.

with high blood levels, even in the presence of food



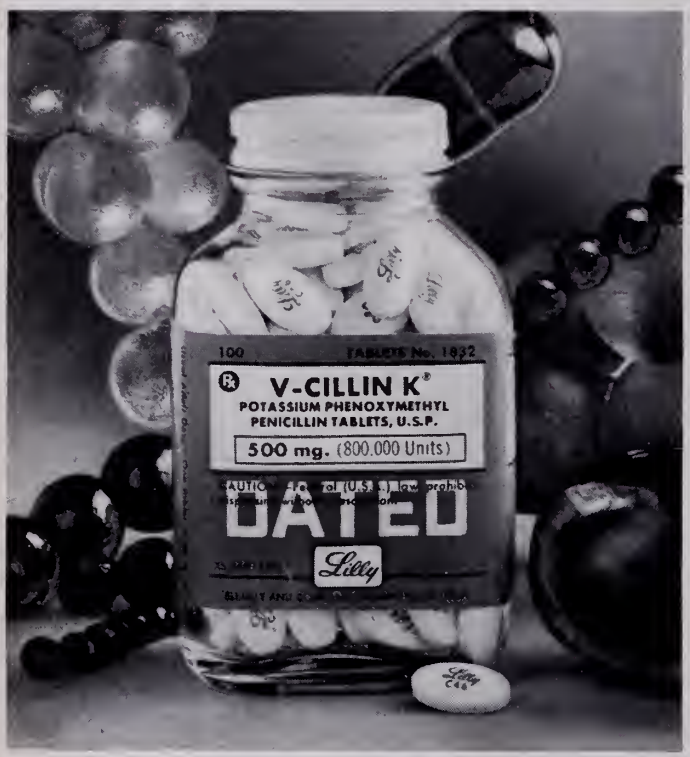
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V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

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Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin hypersensitivity reactions occur, the drug should be discontinued.

Adverse Reactions: Although serious allergic reactions are mu less common with administration of oral penicillin than with intramusc lar forms, skin rash, symptoms resembling those of serum sickness, other manifestations of penicillin allergy may occur. When penicillin administered, measures for treating anaphylaxis should be read available. Those include epinephrine, oxygen, and pressor drugs f relief of immediate allergic manifestations as well as antihistamin and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the ov growth of antibiotic-resistant organisms; in such a case, antibiotic d ministration should be stopped and appropriate measures taken.

Administration and Dosage: For Tablets V-Cillin K and for V-Cil K, Pediatric, the usual dosage ranges from 125 mg. (200,000 unit three times a day to 500 mg. (800,000 units) every four hours. For fants, the daily dosage may be 50 mg. per Kg. of body weight divid into three doses.

Beta-hemolytic streptococcus infections without associated bac remia may be treated with 200,000 to 400,000 units three times a d Therapy should be continued for a minimum of ten days to prevent d velopment of rheumatic fever and/or other serious complications. D age for routine streptococcus prophylaxis in patients with a history rheumatic fever or congenital heart disease may be 200,000 units on or twice daily. When such patients undergo tonsillectomy, tooth extr tion, or other minor surgery, the prophylactic dose should be 500,0 units every six hours given two days prior to surgery and for two d postoperatively. If oral medication is not feasible on the day of s gery, parenteral therapy should be considered. Mild to moderat severe pneumococcus pneumonia has been treated effectively w 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be gi every six to eight hours in conjunction with indicated surgical pro dures.

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Answers to Questions About Your Blue Cross-Blue Shield 65

Q. What variations of in-hospital medical (non-surgical) endorsements are available through Blue Shield?

A. Blue Shield offers a variety of in-hospital medical endorsements. Endorsement I begins on the 4th day. Endorsements II and VI provide $5 for visits beginning on the 1st day. Endorsement IX provides $15 for the visit of the 1st day, $10 for the 2nd visit, $4 for visits on days through 10, and $3 for visits on the remaining days up to 70. The purchaser decides which plan he desires.

Q. Does Blue Shield provide any allowances for diagnostic X-rays or laboratory examinations?

A. Yes, provided the member has purchased this type of protection. With Endorsements V or V-A, which are available to eligible groups, indemnity allowances are provided for the various procedures which are required in the diagnosis of a condition of disease or injury. Allowances are also made under the Extended Benefits and Major Medical programs.

Q. Do I file claims with Kentucky Blue Shield for members of other state Blue Shield Plans?

A. No. File with the state Plan through which the member has his Blue Shield. Plan addresses may be found at the back of the Participating Physicians Manuals.

Q. Do Federal employees belong to any particular state Blue Shield Plan?

A. No. This is a national program, but doctors' allowances differ because some Blue Shield Plans are Service and some are Indemity, and these claims are paid on the basis of the local Plan's policy. The claim should be filed with the Plan located where the service was rendered. All membership records are maintained in Washington, D. C.

Q. In administering emergency accident X-ray claims, what constitutes an accident? An injury?

A. It must be a traumatic condition. It must be associated with trauma.

Q. Does Blue Shield pay for the services provided by osteopaths and oral surgeons?

A. If the procedure performed is an item covered in the contract Blue Shield will make an allowance to the subscriber unless he includes an assignment of benefits with the billing, in which case payment will be made to the osteopath or oral surgeon.

Q. Does the Federal employees' contract cover office or home calls?

A. Only in the Supplemental coverage. Charges to the patient have to exceed $100 in a calendar year for the High Option plan, after which the Supplemental covers 80 per cent of reasonable and customary charges. Those with the Low Option must pay $150 out-of-pocket, and the Supplementary pays 75 per cent of the remaining reasonable and customary charges.



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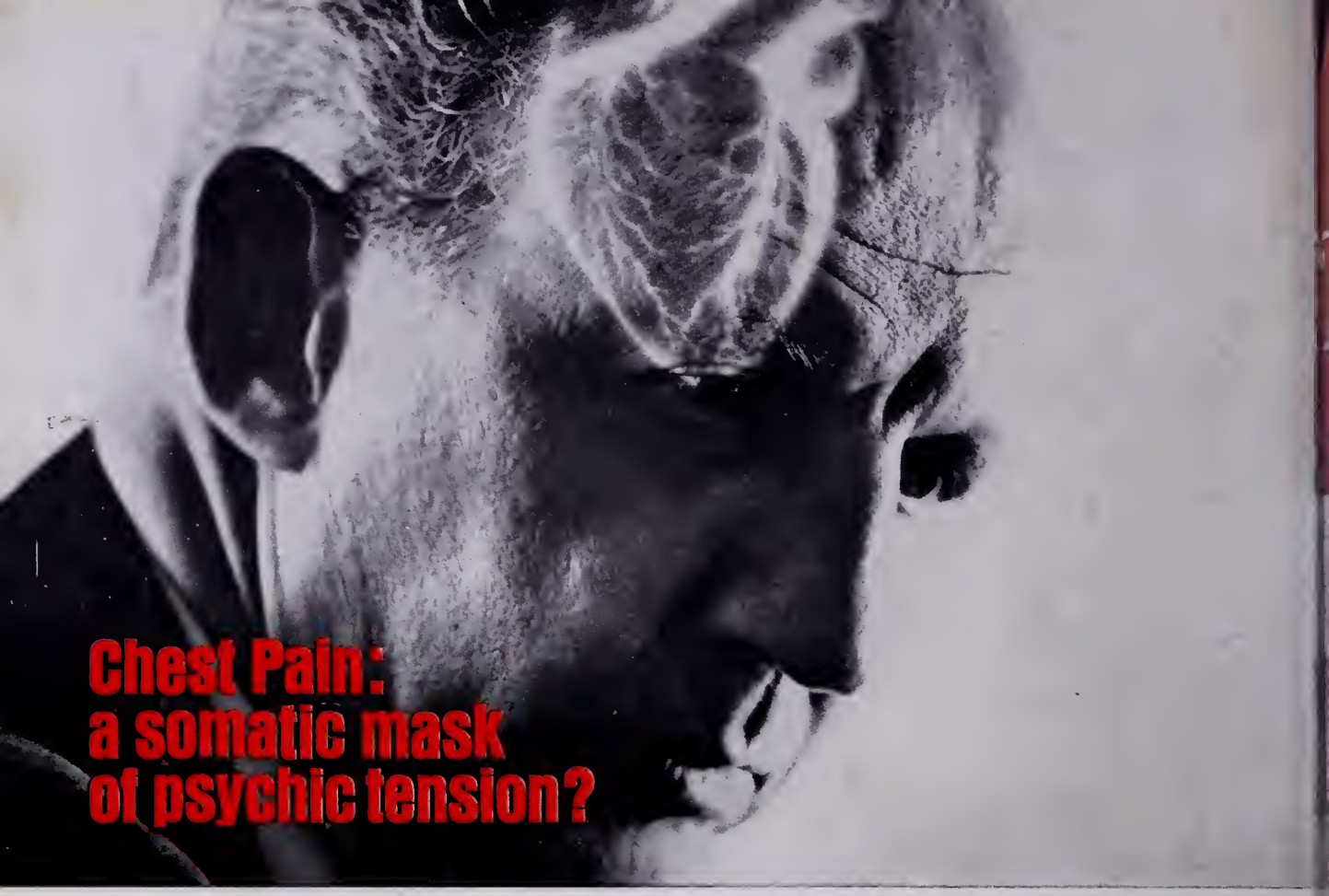
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"Heart symptoms"—chest pain, tachycardia, arrhythmia—invariably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 for convenience and economy in prescribing.

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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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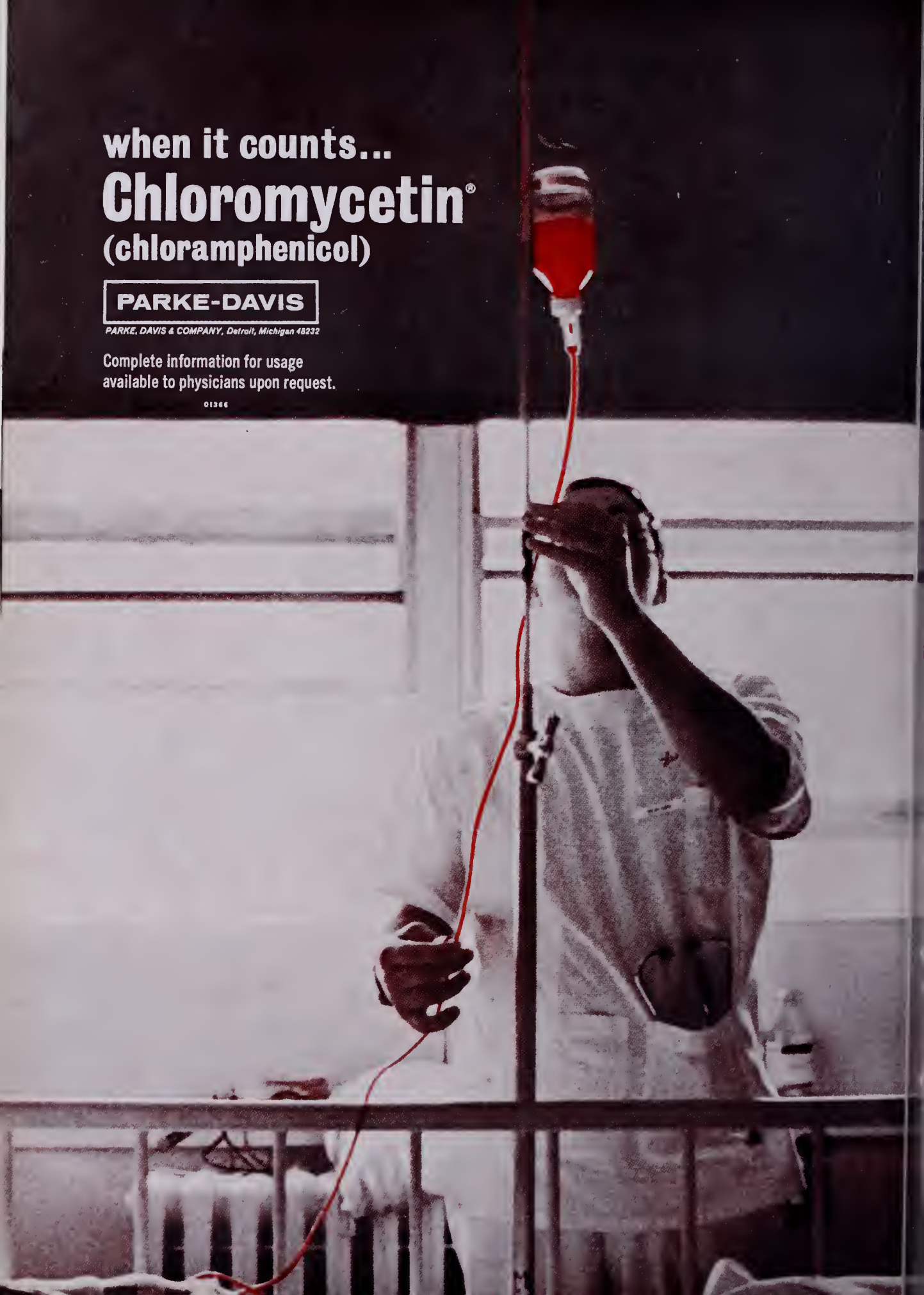
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KMA 1967 Interim Meeting—April 19 and 20

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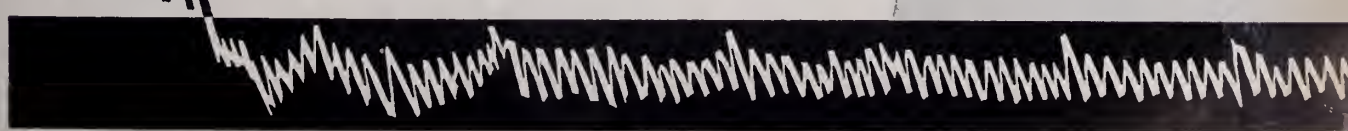
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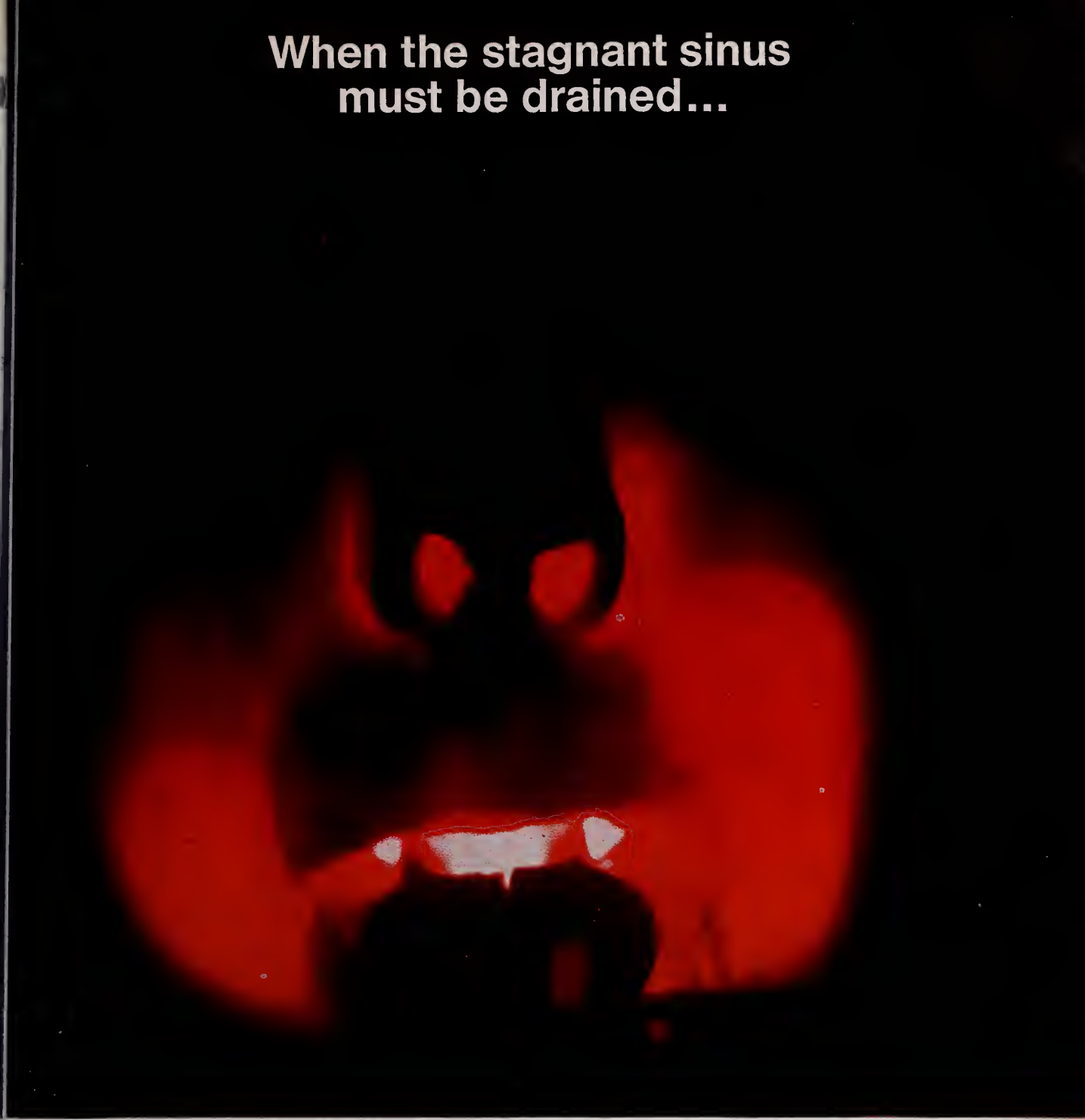
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MESSAGE FROM THE PRESIDENT



Brotherhood of the Caduceus*

HISTORY calls the brotherhood of the medical profession to pause and hearken to the admonitions and awesome responsibilities bequeathed to us by our medical ancestry. AMA President-Elect, Milford O. Rouse, M.D., recently reviewed the history of art and science of medicine in a speech, entitled *THE 5000 YEAR SEARCH.*

We should study our great lineage, hopefully good and honorable in the past, determining its strengths and its weaknesses as well, as to render our profession incapable of pettiness in thought, word, and deed. Further, we should prevent the germination of a class of low crimes common to those who have not the wisdom to learn the dignity and honor of a clean descent, by surrendering our principles.

History speaks distinctly to all physicians, regardless of their mental, moral, financial, or political attributes, and especially to the impressionable young, not to besmirch ignominiously the highest ideals exalted by our medical ancestry. To bedim one ray of a star is to degrade not only himself, but by reflection, his own colleagues. It is not given to all to become heroic, but to each belongs the privilege to hold firmly to his duty in the struggle against insincere, false, diluted, and non-historical doctrines which can pollute and corrupt our brotherhood.

The essentials of a fine medical family are those of good American citizenship clearly delineated in our Constitution; the acceptance and fulfillment of the Oath of Hippocrates; and the courageous, patient, unswerving performance of our duties where our profound concerns lead us.

Historically, certain epochs of our medical history have been in the trough, as well as on the crest of the wave. More recently, we have been forcibly submerged in the trough, but victory calls hopefully for us to reunite, rise to the crest again, and survive. It implies that we be not dismayed but to "Come, labor on—for the strife is not yet o'er nor the battle won."

J. CAMPBELL CANTRILL, M.D.
KMA VICE-PRESIDENT, EASTERN DISTRICT

This is the second of a series of articles written at the request of KMA President Robert E. Pennington, M.D., by the three KMA vice-presidents and the president of the Woman's Auxiliary to KMA. The first article appeared in the January issue of The Journal.

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PROCEEDINGS—WESTERN HEMISPHERE NUTRITION CONGRESS—1965: edited by the Council on Foods and Nutrition; Published by the American Medical Association, Chicago, 1966.

Congresses on specific aspects of health and disease are an expected and needed accompaniment to the exploding volume of scientific research and scientific information. Perhaps the most useful aspect of such gatherings is that they often are designed to furnish an opportunity for highly qualified specialists to select and present, from the overwhelming mass of papers, studies and reports available, the most important problems, observations and developments of the moment. The Congress reported by this book sponsored by two important nutrition groups, was such a meeting. Publishing the Proceedings, a more recent and growing practice, is a most useful development, made possible by liberal financing.

The papers of some seventy-five authors, largely from the Americas, but with some from other areas, are included. Nutritional needs and disorders; food supplementation, development, and regulation; and public health programs are some of the broad areas covered.

This reviewer is pleased to find, in the toxicology section, a presentation on mycotoxins, including *aflatoxin,* a subject receiving much attention in the veterinary and food technology literature but largely ignored in human medical literature.

Indispensable to the nutrition expert and public health worker, particularly if working in developing nations, this book will be useful also to pediatricians, internists and others even in the most advanced societies.

CHARLES F. BLANKENSHIP, M.D.

PRIMER ON PREMATURITY AND HIGH RISK PREGNANCY: by S. Gorham Babson, M.D. and Ralph C. Benson, M.D.; Published by The C. V. Mosby Co., St. Louis, 1966; 194 Pages; Price, $10.50.

This timely publication is designed to bring together the mass of knowledge concerning the low birth weight infant and high risk pregnancy into a form easily accessible to practitioners, house officers, and nursing personnel. The interdisciplinary approach fills the gap in the continuity of medical care of the fetus and newborn where obstetric and pediatric interests coincide or overlap.

The majority of the noncontroversial information concerning prematurity and high risk pregnancy and the management of these conditions is clearly presented in outline form. Modern concepts of the physiology, patho-physiology, and pathology of the fetus and newborn are outlined. Thirty five extremely useful tables and figures are presented and a glossary of new terms and definitions.

The first three chapters include an introduction to the newer, more accurate terminology of this area of medical interest, clinical identification of high risk pregnancy, and an excellent summary of factors concerned in prematurity and high risk pregnancy.

Four chapters summarize very completely maternal infections influencing intrauterine and neonatal life; maternally ingested drugs and their effect on the fetus and the newborn; complications of pregnancy which carry a risk of prematurity; and complications of pregnancy which require early delivery. An excellent statement of the rules and risks involved in elective delivery is also presented.

The chapters on the care of the high risk infant at birth and in the nursery include detailed lists of equipment, drugs, and emergency facilities even down to procedures and equipment for transfer of the infant to a special treatment center.

Special attention is given to the infections, physiologic handicaps, and systemic complications of the high risk infant. One short chapter deals entirely with the problem of discharging the premature infant from the hospital.

The last chapters deal with the sequelae to prematurity and the responsibilities of the physician and the community in the prevention of prematurity and high risk pregnancy.

This volume amply fulfills the author's stated purpose and should have a prominent place on the bookshelf of those involved in the care of the high risk pregnancy and the premature infant. It should be invaluable to those responsible for planning new or updating old hospital facilities expecting to care for this category of patient.

Intelligent employment of the material presented should result in approaching the goals set forth by the authors with regard to reduction of neonatal mortality, perinatal mortality, and premature birth rates.

WALTER M. WOLFE, M.D.

EPILEPSY AND THE LAW, Second Edition: by Roscoe L. Barrow, and Howard D. Fabing, M.D.; Published by Harper and Row, New York, 1966; 174 Pages; Price $6.00.

The second edition of this small volume is as compact and erudite as the first. It is an excellent compendium and report on legal reform in the light of medical progress in epilepsy.

The first edition was published in 1956 and exposed the archaic laws relating to epilepsy with proposals for their reforms. To measure the effectiveness of the book one can best gauge by the words of Chief Justice Earl Warren: "EPILEPSY AND THE LAW probably caused more legislatures to amend

more laws in a shorter period of time than any similar research project of the past two decades".

The book will serve as an excellent reference source for physicians, social workers, family counsellors, employers, workmen's compensation boards, motor vehicle commissions, health departments, etc.

The volume offers an authoritative source material for the changing pattern of laws affecting the epileptic in his relations with marriage, eugenic sterilization, driver's licenses and hiring of the handicapped. There is also some discussion on the immigration laws, life and health insurance, education and criminal liability laws.

The authors point out the fact that the great advances in the understanding and treatment of epilepsy in the past thirty years have doubtless acted as a "legal catalyst causing great legal change". To this the reviewer can only say amen.

In conclusion, then, it may be stated that the volume is a must reading for anyone—medical, paramedical, administrative, or otherwise—whose paths converge on the non-medicinal management of the epileptic.

EPHRAIM ROSEMAN, M.D.

SYNOPSIS OF DERMATOLOGY: by William D. Stewart, M.D., Julius L. Danto, M.D., and Stuart Maddin, M.D.; Published by the C. V. Mosby Company, St. Louis, 1966; 664 Pages; Price $30.00.

This new book on skin diseases is considerably more that a synopsis. It is handy—8x5 inches. It is 635 pages and indexed well. 187 plates and figures, which are truly the best I have seen in any text. The authors are from Vancouver, The University of British Columbia.

There is a section of regional diagnosis of 75 pages. This includes areas such as external ear, legs, female genitalia and three or 4 pages listing the common conditions including this area with a four or 5 line description. Then there is reference to other parts of the book for a more detailed discussion of each subject. This is quite helpful for non-specialists. Sabauroud originally did this and I often have wondered why modern authors do not. Presenting all the usual possibilities of a condition that may occur in a given area will enable a physician to reach the correct diagnosis.

Few choices are given on treatment and rare congenital dermatoses are merely mentioned. This is probably best, as this volume is intended for the General Practicioner and is, for a synopsis, quite complete.

PAUL MAPOTHER, M.D.

PERIPHERAL ARTERIAL DISEASE, Vol. IV, Series, MAJOR PROBLEMS IN CLINICAL SURGERY: by Wiley F. Barker, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1966; 229 Pages; Price, $8.50.

This monograph, with limited scope, deals primarily with chronic occlusive disease of the terminal aorta, the iliacs, and the arteries of the lower extremities.

The section on normal and pathologic anatomy is well illustrated. The reproductions of the angio-

(Continued on Page 310)



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Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

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Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug. Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.



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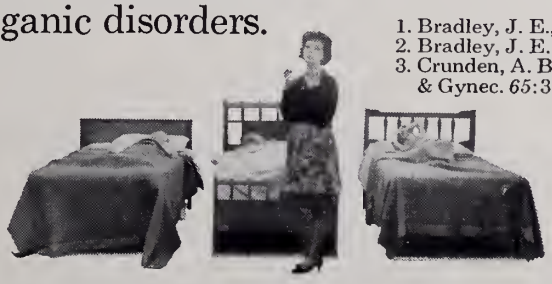
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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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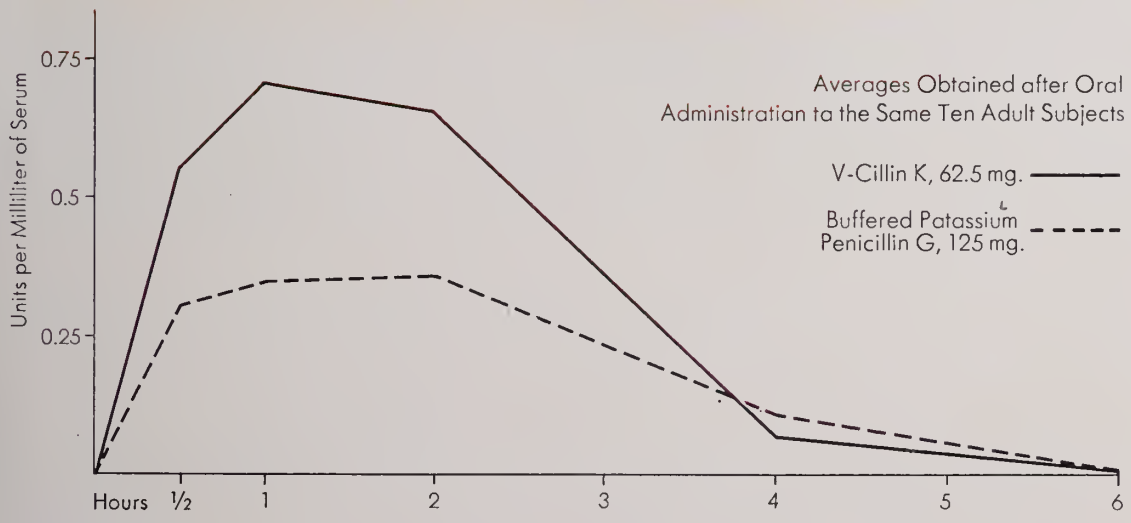
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Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptacaccus, Graup A MIC (mcg./ml.) Median	Range	Diplacaccus Pneumaniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Claxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adopted from Klein, J. O., and Finland, M. New England J. Med ,269 1019, 1963.

with high blood levels, even in the presence of food



Adopted from Griffith, R. S , and Black, H. R. Current Ther. Res., 6 253, 1964.

V-Cillin K® Lilly 700157

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin hypersensitivity reactions occur, the drug should be discontinued.

Adverse Reactions: Although serious allergic reactions are m less common with administration of oral penicillin than with intramu lar forms, skin rash, symptoms resembling those of serum sickness other manifestations of penicillin allergy may occur. When penicill administered, measures for treating anaphylaxis should be rea available. Those include epinephrine, oxygen, and pressor drugs relief of immediate allergic manifestations as well as antihistam and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the o growth of antibiotic-resistant organisms; in such a case, antibiotic ministration should be stopped and oppropriate measures token.

Administration and Dosage: For Tablets V-Cillin K and for V-C K, Pediatric, the usual dosage ranges from 125 mg. (200,000 un three times a day to 500 mg. (800,000 units) every four hours. Fo fants, the doily dosage may be 50 mg. per Kg. of body weight divi into three doses.

Beta-hemolytic streptococcus infections without associated bo remia may be treated with 200,000 to 400,000 units three times a Therapy should be continued for a minimum of ten days to prevent velopment of rheumatic fever and/or other serious complications. I age for routine streptococcus prophylaxis in patients with a histor rheumatic fever or congenital heart disease may be 200,000 units o or twice daily. When such patients undergo tonsillectomy, tooth ext tion, or other minor surgery, the prophyloctic dose should be 500 units every six hours given two days prior to surgery and for two postoperatively. If oral medication is not feasible on the day of gery, parenterol therapy should be considered. Mild to moderc severe pneumococcus pneumonio has been treated effectively 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be g every six to eight hours in conjunction with indicated surgical pr dures.

For gonorrhea in males, 500 mg. (800,000 units) every six hour three doses may be employed; in females, 500 mg. every four hour six doses are recommended. Patients with a suspected lesion of syp should have a dark-field examination before receiving penicillin monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (800 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packoges.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate.....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2),
½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

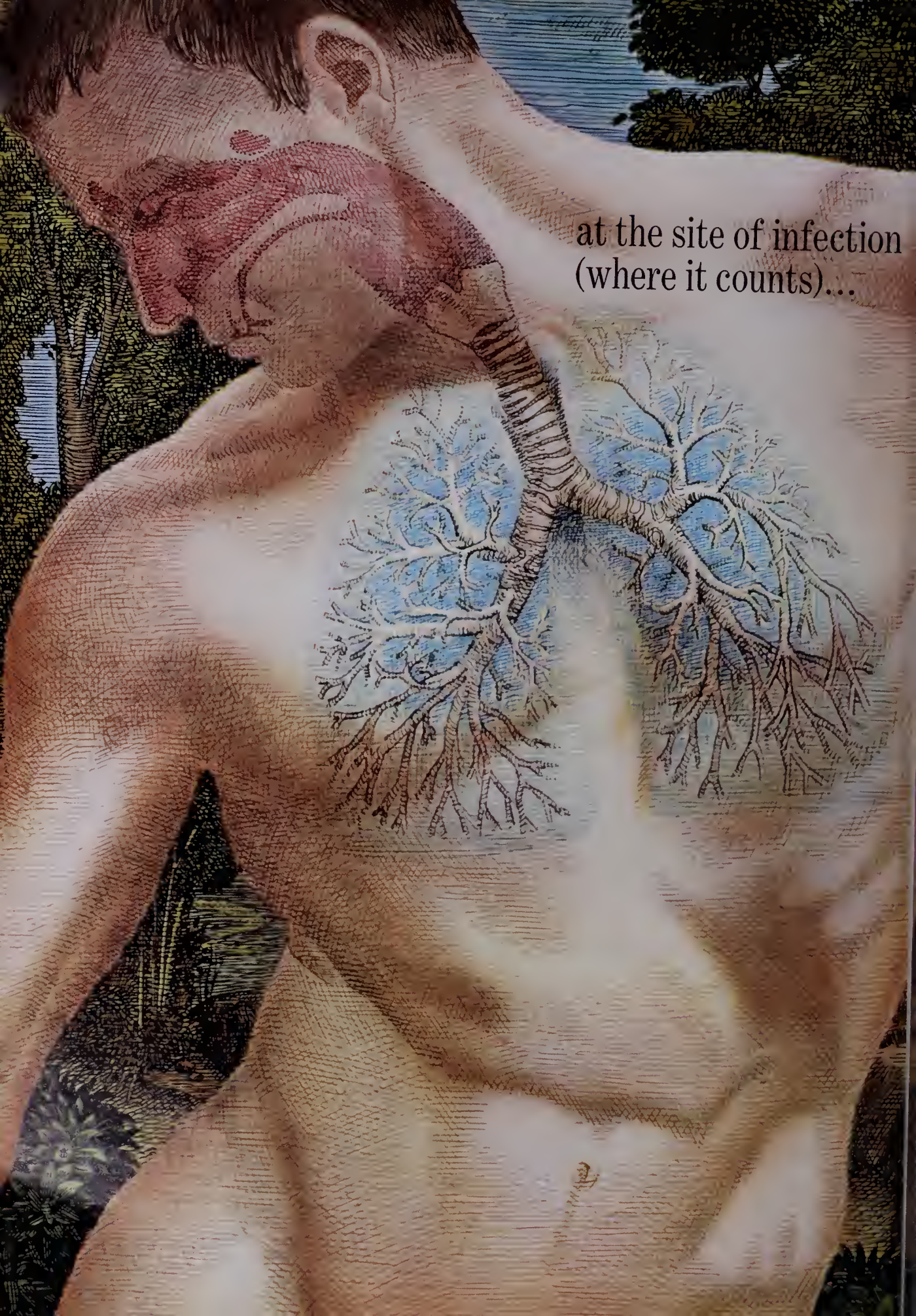
Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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A. H. ROBINS CO., INC., Richmond, Va. 23220


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®

Lilly

Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings v characterized by increased direct-reacting bilirubin, elev alkaline phosphatase levels, negative or weakly positive cepl flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has been reported in other patients taking prolonged courses of medication. Patients with chronic infection have been given to 2 Gm. of the drug daily for periods of two to six months, patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one grou 144 patients who received the drug daily for two years, no j dice was noted. It was of interest that members of six of t patients' families, who were not taking the drug, had epis of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels v determined in a group of fifty-four adults and children who 250 mg. of Ilosone daily for an average of sixteen month rheumatic fever prophylaxis. The results were compared v those of a similar group of forty-four patients who received icillin. There were no cases of jaundice in either group. Eleva of SGPT and serum alkaline phosphatase levels during the co of treatment was observed in one patient treated with Ilo and in two patients treated with penicillin. Seven other pati in the group receiving Ilosone and four others in the penic group showed elevations in one of the tests at some time du administration of the drugs.

Very satisfactory therapeutic results, without toxicity, v reported in 102 pediatric patients who received short-term (day) courses of Ilosone in the treatment of streptococcus in tions. Results of liver function tests in these patients were c parable to those in a similar control group who had rece penicillin.

Gastro-intestinal disturbances not associated with hepatic fects are observed in a small proportion of individuals as a re of a local stimulating effect of the medication on the aliment tract; however, the normal intestinal gram-negative bacte flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the of erythromycin, there have been occasional reports of urtica skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of b weight, the usual dosage is 5 mg. per pound every six hours; children twenty-five to fifty pounds, 125 mg. every six ho (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual dos of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythrom therapy should be considered.

In the treatment of syphilis, the recommended total dosag 20 to 30 Gm. given in divided doses for a period of ten to fift days. Close follow-up of the patient is necessary since eryt mycin drugs have not had adequate evaluation in all stage syphilis. Examinations of spinal fluid are recommended as p of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days recommended. In the treatment of gonorrhea, patients wit suspected lesion of syphilis should have a dark-field examina before receiving antibiotics, and monthly serologic tests sh be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to ba in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10- size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equival to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packa

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 196

Additional information available to physicians upon request.
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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

The Department of Radiology of the University of Kentucky Medical Center will present a symposium on "Current Concepts in Chest Radiology: Pathophysiological Correlations" from May 1 to May 5, 1967. Radiologic findings will be explained in terms of basic underlying pathological mechanisms. A distinguished Visiting Faculty and staff members of the College of Medicine of the University of Kentucky will participate in this symposium. A Film Seminar will be conducted at the end of each day. For further information, contact Harold D. Rosenbaum, M.D., University of Kentucky Medical Center.

IN KENTUCKY

APRIL

6 Third Governor's Occupational Health Conference, Lexington

14-15 "Neurology-Neurosurgery for the Non-Neurogist," College of Medicine, Lexington ($15 fee)

19-20 KMA Interim Meeting, Ken-Bar Inn, Gilbertsville.

20 U of L School of Medicine, in cooperation with the Ky. Chapter of the Arthritis Foundation, one day Symposium on Rheumatic Diseases, "Osteoarthritis and Related Disorders', Rankin Amphitheater, Louisville General Hospital.

22 Industrial Doctors and Nurses, Executive Inn, Louisville (All day meeting)

29-30 Thirteenth Annual Symposium on Cardiovascular Diseases, Brown Hotel, Louisville. Sponsored by the Heart Association, Jefferson County Academy of General Practice, and University of Louisville School of Medicine.

MAY

1-5 Symposium on "Current Concepts in Chest Radiology: Pathophysiological Correlations", Department of Radiology, University of Kentucky Medical Center, Lexington

10-12 16th Annual KAGP Scientific Assembly, Convention Center, Louisville (Sheraton Hotel, Headquarters)

18-20 Kentucky Ob-Gyn Society, Annual Meeting, Lexington

IN SURROUNDING STATES

MARCH

29-30 Cleveland Clinic Educational Foundation, "Medical Progress and its Relationship to Dentistry", Bunts Auditorium, Cleveland

30-April 1 American Academy of Pediatrics, Stanford University of Medicine, Palo Alto, Calif.

APRIL

3-7 40th Annual Spring Congress in Opthalmology and Otalaryngology, Gill Memorial Ear, Eye and Throat Hospital, Roanoke, Va.

5-6 Cleveland Clinic Educational Foundation, "Diagnosis Procedures in Gastroenterology," Bunts Auditorium, Cleveland

10-13 Industrial Medical Association, Americana Hotel, New York

10-13 Southwestern Surgical Congress, Del Webb's Towne House, Phoenix, Ariz.

10-14 American College of Physicians, Fairmont Hotel, San Francisco

17-20 American College of Obstetrics and Gynecologists, Hilton Hotel, Washington, D.C.

24-26 AMA National Congress on Environmental Health Management, Hotel Americana, New York

26-27 Cleveland Clinic Educational Foundation, "Diabetes Mellitus: The Old and the New," Bunts Auditorium, Cleveland

MAY

3 American Cancer Society Symposium, "Current Concepts in Etiology and Diagnosis of Cancer," Sheraton-Dallas Hotel, Dallas, Tex.

6 American College of Psychiatrists, Annual Meeting, Detroit

16-19 Ohio State Medical Association, Columbus

21-24 National Tuberculosis Association, American Thoracic Society, and National Conference of Tuberculosis Workers, Penn-Sheraton, Pittsburg

JUNE

15-19 American College of Chest Physicians, Atlantic City, N.J.

18-22 American College of Preventive Medicine, Atlantic City, N.J.

12-22 American Medical Association, Annual Meeting, Atlantic City, N.J.


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VOLUME 65 March 1967 No. 3

Visceral Manifestation Of Polymyositis

HERBERT N. HARKLEROAD, M.D.* AND GILBERT B. BLUHM, M.D.**

A patient with polymyositis featuring extensive visceral involvement is described, and published reports on this unusual entity are reviewed.

POLYMYOSITIS, a disease profoundly affecting skin and muscle, may on occasions feature visceral involvement. Visceral manifestations involving the esophagus and intesinal tract are common. Less frequently seen early in the disease are heart, lung and kidney abnormalities[1-4]. The purpose of this report is threefold. First, a patient will be described who manifested renal, pulmonary and cardiac abnormalities with the initial symptoms and signs of acute myositis; second, the post mortem findings obtained 22 months after the onset of the myopathy will be recorded; and third, the visceral manifestations of polymyositis documented in the world literature will be summarized.

Case Report

J. D., a 39 year old negro male, employed as a shear line laborer in a steel company, was first seen at Henry Ford Hospital in September, 1957 with complaints of swelling and soreness in the left wrist of three months duration. Stiffness of several joints had occurred periodically for the previous six years. There was no history of iritis or renal stones. The patient had no urethral discharge. The physical examination revealed a swollen, warm, and tender left wrist joint with limitation of motion. The Proximal Interphalangeal joint of the right index finger was spindle-shaped and limited in movement. X-rays showed a destructive process in this joint but no joint destruction in the left wrist. A diagnosis of atypical rheumatoid arthritis was entertained. Treatment consisted of rest, and physiotherapy.

On subsequent out-patient visits, he still had pain, swelling, and limited motion in the left wrist. X-rays in May, 1961 showed narrowing of the intercarpal joints. The sedimentation rate was 29 millimeters in one hour, and the latex fixation for rheumatoid factor was nonreactive.

The patient next came to the out-patient department in January, 1962. He reported that six weeks previously, after a prolonged weekend car trip, he noted progressive pain, stiffness and weakness of both knees. The discomfort kept him away from work the week preceding the examination.

He was well-developed and well-nourished, but walked hesitantly and with a shuffle. His temperature was 101.6F. His skin was warm and dry. Poikiloderma was evident about his face and neck. Skin turgor was normal. The Proximal Interphalangeal joint of the right index finger was enlarged and limited in motion. The left wrist was painful, moderately swollen, and moved through only a 30 degree range. There was bilateral effusion of the knees with pain and limitation of movement

*From the Division of Rheumatology, Henry Ford Hospital, Detroit, Michigan. Reprint requests to Doctors Building, Bowling Green, Kentucky (Dr. Harkleroad).

**Associate Physician, Division of Rheumatology, Department of Medicine, Henry Ford Hospital, Detroit, Michigan.

as well as general tenderness of the muscles of the extremities. Strength was decreased in the lower extremities. The heart tones were normal with a sinus tachycardia of 110 per min. Bronchial breath sounds and inspiratory dry rales were heard posteriorly in the lower half of both lung fields. Abdominal examination was negative. The patient was admitted to the hospital for observation and treatment on January 10, 1962.

The patient's condition remained essentially unchanged during the first week of hospitalization. His temperature fluctuated between 99 and 102 F. The atelectatic rales, bronchial breath sounds and techycardia persisted. Treatment consisted of bedrest, salicylates and physiotherapy. Significant laboratory data included the following:

WBC 15,300 per mm^3 with neutrophils 94%. Sputum smears and cultures were negative. Cold agglutinins, skin tests for tuberculosis and fungus, and three peripheral L. E. tests were negative. BUN 67 mg./per 100 ml. Sedimentation rate 34 mm./hr. Serum albumin 2.42 g.%. Serum gamma globulin 1.94 g.%. Albuminuria 2.42 g./24 hours. Chest x-ray revealed a diffuse infiltrative process involving predominantly both lower lobes (Figure 1). Synovial fluid aspirated from the left knee showed a WBC of 28,500 per mm^3 with 86% Neutrophils. A synovial biopsy revealed acute synovitis.

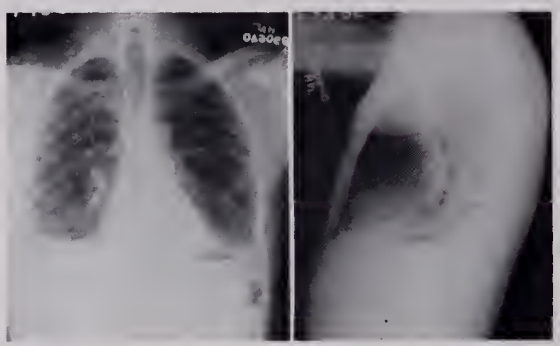


FIGURE 1: PA and lateral of the chest, January, 1962. Diffuse parenchymal infiltration predominantly in the lower lobes and left pleural effusion.

On the ninth hospital day, swelling (pseudohypertrophy) of the entire right arm from the shoulder to the hand was noted (Figure 2). There was no pitting edema or muscle tenderness but marked weakness in the arm. On subsequent days progressive weakness of all muscle groups in both upper extremities developed, the proximal muscle groups being more strikingly affected. Weakness in the lower extremities was difficult to evaluate because of the inflamed knee joints. As the synovitis subsided, primary weakness of the proximal muscles in the lower extremities became apparent. Serum glutamic oxaloacetic transaminase was 1000 units/ml./min., (normal less than 40) and lactic dehydrogenase was 2000 units/ml./min., (normal less than 400). Twenty-four hour urinary creatine and creatinine was 1246 mg/vol and 1443 mg/vol. respectively.



FIGURE 2: Patient exhibits pseudohypertrophy of the right arm and forearm.

A biopsy of the right biceps muscle performed on 26 January 1962 showed extensive degeneration of muscle (Figure 3). There was marked swelling of individual muscle fibers with necrosis and loss of cross striation. Vacuolization of fibers was present and in some places complete absence of sarcoplasm. The muscle fibers and interstitial tissue were prominently infiltrated with plasma cells and neutrophils. Some fibrosis was noted. Pathologic diagnosis was active myositis. The patient was started on prednisone 60 mg. per day on 29 January 1962.

Serial BUN studies reflected a moderate improvement in the patient's nephropathy with only bedrest and the supportive measures outlined. This improvement continued with adrenal corticosteroid administration. Marked albuminuria was established on two occasions with levels of 2.4 g. and 2.2 g. in 24 hours. Urine test for myoglobin was negative.

The cardiac findings suggested active myocarditis and pericarditis. A tachycardia was manifested from the beginning of his illness. On

26 January 1962 a gallop rhythm was noted, initially presystolic and later changing to a protodiastolic gallop. A pericardial friction rub persisted for four weeks. On 24 February and 28 February 1962 the patient exhibited transient episodes of auricular fibrillation. He was digitalized during the second episode of auricular fibrillation after which the arrhythmia converted to a sinus rhythm. No further arrhythmias or friction rubs were detected.

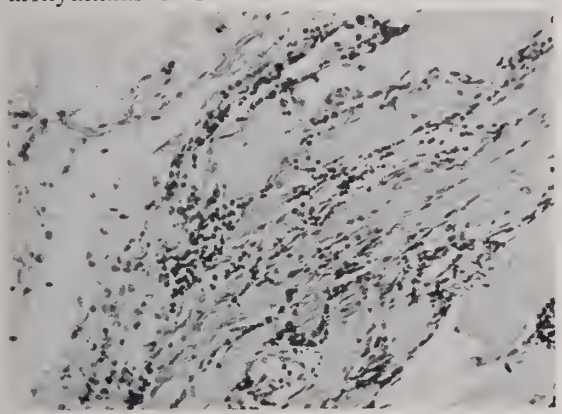


FIGURE 3: Histological section (325 x). Biopsy from the right bicep muscle. Note marked exudative inflammatory cell infiltrate, loss of cross striation in the muscle fiber and muscle necrosis.

Chest x-ray on admission revealed a diffuse infiltrative process involving predominantly both lower lobes and considerable reduction in volume of the lower lobes (Figure 1). Physical examination of the chest revealed dry inspiratory rales and rhonchi posteriorly in both lower lung fields. The patient had surprisingly few pulmonary symptoms, despite the auscultatory and roentgenographic changes. Approximately six weeks after initiating adrenal corticosteroid the rales disappeared. Three weeks later the tubular breath sounds became bronchovesicular. Serial chest x-rays showed gradual clearing and by 26 June 1962 there was complete clearing of the infiltrative changes (Figure 4).

The patient's clinical status closely paralleled the improvement in certain laboratory studies (Figure 5). Subjective improvement occurred within 24 hours after prednisone was started. Joint distress disappeared, appetite improved, and he became afebrile. The right arm returned to normal size within two weeks. The marked proximal muscle weakness of both upper and lower extremities was the most profound and persistent finding on daily examination. The patient could not raise himself from a lying or a sitting position. Improvement in muscle strength began during the fourth week of prednisone treatment. However, it was four months before full strength returned.

Prednisone was continued at 60 mg. per day for five weeks. Iatrogenic Cushingoid features failed to develop during the treatment period, despite the prolonged high daily dose. Prednisone dosage was slowly reduced and was 40 mg. per day when the patient was discharged on March 30. Gradual reduction in dosage was continued on an out-patient basis without an exacerbation of myopathy.

The patient returned to work five and one-half months from the date of hospital admission. At that time he had excellent strength in all extremities and essentially no complaints. He had normal cardiac, renal, and pulmonary findings by laboratory and physical examination. All joints were normal to examination except the changes in the left wrist and right index finger which were present prior to the onset of myopathy.

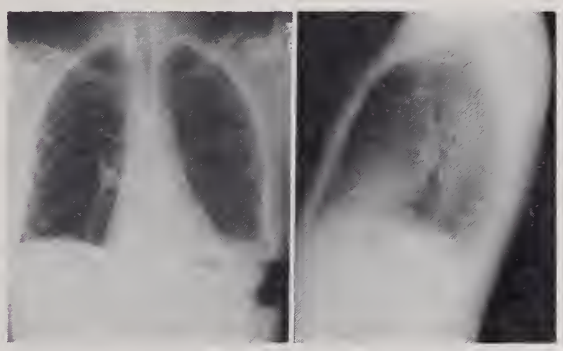
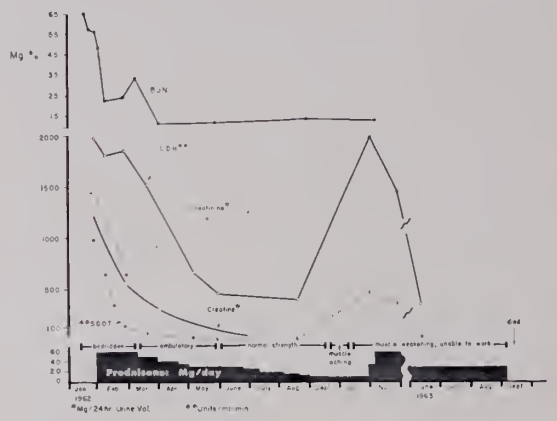


FIGURE 4: PA and lateral x-ray of chest showing complete resolution of infiltrative changes and effusion.

In October 1962, the patient's illness exacerbated despite a maintenance prednisone dose of 10 mg per day. Improvement was slow even with increased prednisone intake. From January to June of 1963 the convalescence failed to match the clinical recovery of the first remission, and the patient was never able to return to full activity. The limiting factor became dyspnea, although the myopathic symptoms receded. In September 1963, while hospitalized at Veterans Administration Hospital, Dearborn, Michigan, he developed a sudden attack of severe orthopnea and died. The following synopsis was made from the autopsy protocol provided by the pathology Department, Veterans Administration Hospital, Dearborn, Michigan.*

*Courtesy of Dr. T. Knechtges, Pathologist VAH, Dearborn, Michigan.

"The skin of the face exhibited alternate areas of hyper and hypopigmentation that was thick and firm. Other skin areas were considered grossly normal. Microscopic sections revealed mild atrophy of the skin.



(June 1962)

FIGURE 5: Interrelations of clinical course, laboratory data, and prednisone therapy.

The pericardial sac contained 2 ml of clear light yellow fluid. The pericardium and epicardium were firmly adherent throughout. The lung adjacent to the pericardium on the left side was also adherent.

The heart weighed 550 gms. Although generally enlarged, the left ventricle was the predominantly affected chamber. The myocardium was firmer than usual, red-gray throughout, but with a deep red color in the posterior wall. The valves and ostium were unremarkable except for the tricuspid valve, which showed gray-white, firm, thickened nodularities of the cusp, involving the free margin and the chordae tendinae. The coronary arteries revealed a balanced distribution and only minimal patchy arteriosclerosis. Tissue sections revealed focal perivascular and interstitial fibrosis of the myocardium, myocardial hypertrophy and adhesive fibrous pericarditis.

The pleural cavities were free of fluid but the left lung adhered throughout to the left hemithorax. The right lung was 710 g and the left 560 g in weight. Purple discoloration of the right lower lobe, posterior aspect, was noted. Both lungs cut with increased resistance and no fluid could be expressed except a minimal amount from the right lower lobe. The striking microscopic appearances was a severe interstitial fibrosis and small pulmonary thromboemboli.

The alimentary tract was grossly normal; however, microscopic sections revealed mild submucosal fibrosis of the esophagus.

The liver was 2200 g and the spleen 100 g in weight. Except for the mild fatty metamorphosis of the liver, significant changes were absent in either organ.

The kidneys weighed 150 g (right) and 180 g (left). Both cut readily and the capsule stripped easily. The cortex measured 0.5 cm. thick throughout, a red-brown color prevailed except for focal gray-white areas near the capsule. A severe, diffuse, obliterative endarteritis with intimal proliferation was evident and marked diffuse glomerulofibrosis and fibrinoid change were also seen microscopically. Multiple recent focal infarcts were present.

The expected adrenal atrophy accompanying long term adrenal corticosteroid therapy was evident. The other viscera examined were normal.

The sudden death was attributed to Pulmonary Embolism."

Discussion

Polymyositis is a relatively rare disease, even in its more common presenting form of skeletal muscle inflammation and dermatitis. Much more rare, as indicated by the scarcity of case reports, is involvement of the visceral organs. When such visceral organs are affected, the disease may take many forms in its clinical presentation. Affections of any one of these organ systems, i.e. lungs, heart, or kidneys, may predominate during the illness, and hence overshadow in magnitude and seriousness all other features of the disease.

LUNGS:

In 1956 Mills and Mathews[3] reported the first case of polymyositis in which the predominant clinical signs and symptoms were referable to the lungs. Treatment with cortisone and corticotropin failed to influence the downhill course, and the patient died six weeks after hospital admission. The authors reviewed the literature on polymyositis and found that in 66 cases by 13 different authors, pulmonary signs and symptoms were not a feature of the disease at any time.

Two cases of polymyositis with mild pulmonary fibrosis were reported by Gil.[5] Clinically the patients manifested a dry, chronic cough and slight dyspnea. Chest x-rays showed

light bands of increased density in the interstitial tissue of the lung parenchyma. In a case reported by Gravano[6], there were diffuse bronchial breath sounds in both lung fields. Percussion dullness over the lower lung fields was also present, but no changes could be seen radiographically. Bilateral apical infiltrates and a pleural effusion in the lower third of one lung occurred in one patient with acute dermatomyositis reported by Domzalski and Morgan[7]. Both the effusion and apical infiltrates resolved without treatment within four weeks. Dubowitz[8] reported a 5 year old male, later diagnosed as dermatomyositis, whose presenting findings were those of a respiratory infection, including shallow respiration, vesicular breath sounds, and rales in both bases.

Goldfischer and Rubin[1] reported a case of dermatomyositis in which the pulmonary lesions were confirmed by antemortem lung biopsy. Fine rales and rhonchi were heard throughout both lung fields. Chest x-ray showed diffuse fibrosis and emphysema with superimposed patchy areas of pneumonic consolidation.

Pace[9] reported 2 cases of dermatomyositis with pulmonary function studies similar to that seen in Progressive Systemic Sclerosis. The first, a 37 year old male, had normal clinical chest findings with the exception of a few dry basilar rales. His vital capacity was 90% of the predicted value, but an alveolar-capillary membrane permeability defect and a ventilation perfusion abnormality were demonstrated. He later developed pulmonary hypertension and cor pulmonale. The second patient, a 45 year old female, had decreased breath sounds and decreased chest excursion, but no rales or wheezes. A restrictive ventilatory defect, a marked membrane diffusion defect, and ventilation-perfusion abnormalities were found on pulmonary function evaluation. The vital capacity was 42% of the predicted value, and the maximum breathing capacity was 45% of that predicted.

Lesions of the lungs may be acute and reversible, or on occasion chronic and irreversible. With significant degrees of impairment, the patient usually complains of dyspnea and a dry cough. Breath sounds may be bronchial and frequently rales or rhonchi are noted. X-ray findings include pleural effusions, localized or diffuse infiltrations, and occasionally advanced changes of interstitial fibrosis and emphysema.

CARDIAC:

Cardiac abnormalities occurring in acute polymyositis were first reported by Lorenz in 1906[10]. Persistent tachycardia, without relation to fever, is the only clinical manifestation commonly seen[11,12]. Electrocardiographic change suggesting myocardial or pericardial involvement has been recorded by a number of observers[6,13-11], and necropsy changes have occasionally been reported[18-21].

With myocardial involvement in polymyositis, the electrocardiogram usually shows nonspecific changes such as ST depressions and flat or inverted T waves[14]. Bacher[15] found electrocardiographic alterations in 33 of 102 cases of biopsy proven polymyositis. Other than sinus tachycardia, the most common changes were depressed ST segments and flat or inverted T waves. Eight of 27 patients with biopsy proven polymyositis from the Mayo Clinic[15] had electrocardiographic changes. The most frequently observed change was a low amplitude QRS in the standard leads.

Gravano[6] reported a patient with T wave changes in leads V1, AVL, V5 and V6 who had cardiomegaly radiographically. DeRosa[16] reported a 35 year old female with polymyositis whose electrocardiographic changes improved following the use of adrenal corticosteroids. Grivaux[22] reported a 60 year old female who showed ischemic changes on electrocardiogram and manifested a presystolic gallop clinically. Alternating bundle branch block occurred in a case report by Christensen and Levison[20], and necropsy later disclosed myocardial degeneration.

Arrhythmias are not common but have been reported in polymyositis. Auricular fibrillation is listed as occurring in dermatomyositis by Domalski and Moran[7], but they do not cite the case in reference. Three patients reported by Bacher[15] had conduction defects, but the type is not described. Mendeloff[21] reports one patient who exhibited second degree heart block with 3 to 1 A-V dissociation. Necropsy revealed focal necrosis of groups of myocardial cells in both the left ventricular and the interventricular septum. Garcin et al[23] reports a patient who developed complete AV block two years after the onset of dermatomyositis. The ventricular rate varied between 20 and 40 per

min., and the patient manifested typical Stokes-Adams attacks. Two cases with complete heart block and Stokes-Adams attacks were reported by Siguier[17]. In one of these an internal pacemaker was implanted and worked efficiently for six months.

Walton and Adams[2] found that four of their forty patients with polymyositis had signs of pericarditis. In one of these there was a substantial effusion. Three of ten patients reported by Gil had cardiac disease, one of which had pericarditis. A second patient had cor pulmonale and the third a changing diastolic murmur.

Coronary heart disease, including angina pectoris[24] and myocardial infarction[17,24] are reported in polymyositis, but one may reasonably question if there is a true causal relationship between the polymyositis and coronary artery disease. One possible mechanism to explain their relation is suggested in a case reported by Taubenhaus et al[14] in which platelet thrombi were found in the small myocardial vessels at necropsy.

Clinical evidence of cardiac involvement is often heralded by a sinus tachycardia. Arrhythmias, changing murmurs, pericardial friction rub or effusion, or cardiac enlargement may follow. Small QRS complexes and non-specific changes of the ST segment and T wave are the most common electrocardiographic changes, although atrial fibrillation, atrio-ventricular block, bundle branch block, and myocardial infarction have been documented in polymyositis.

RENAL:

Oppenheim[25] stated in his text in 1923 that nephritis is a common complication of dermatomyositis, but failed to offer adequate evidence to substantiate his thesis. One year later Weber and Gray[26] contended that the kidneys were usually spared in dermatomyositis. Recent medical reviews substantiate that renal involvement is, indeed, rare with polymyositis[11,27,28]. Some authors report minor alterations occurring in the urinalysis with polymyositis. Sheard[29], for example, records albuminuria in 18 of 25 cases, plus the occasional occurrence of red blood cell casts. Albuminuria and casts occurred in one case reported by Gil[5], but the patient was in congestive heart failure at the time.

Talbott et al[30] reported a case of a 26 year old white female who developed weakness in the arms and legs six weeks port-partum. She exhibited a delayed PSP excretion and a fixed urinary specific gravity of 1.010, but no albuminuria. Necropsy revealed a severe generalized myositis and renal tubular necrosis secondary to endarteritis of the interlobular arteries. A diagnosis of dermatomyositis was entertained.

Walton and Adams[2] report two patients with polymyositis who died in uremia. Blocking of renal tubules with myoglobin was subsequently shown at autopsy in these cases. This phenomena as a cause for renal failure was first demonstrated experimentally by Bywaters and Stead[31] with the intravenous injection of solutions containing myoglobin.

Renal involvement in polymyositis may be manifested on routine urinalysis by proteinuria, hematuria or casts. Functional impairment is further evidenced by an elevation of the blood urea nitrogen or by a delay in PSP excretion. Occasionally, myoglobinuria can be demonstrated.

Conclusion

The most striking clinical features of the acute illness in the present reported case were the prominent swelling of the right arm and the extreme proximal muscle weakness of all extremities. These findings in association with the marked elevation of serum enzymes and the microscopic evidence of severe acute myositis clearly distinguished the primary disease as Polymyositis. Involvement of such vital organs as the heart, kidney, and lung in this disease entity, however, is rarely observed as indicated in the foregoing review of the world literature. The profound visceral involvement in this patient therefore deserves special emphasis, particularly from at least three viewpoints.

First, it emphasizes the intimate clinical relationship which polymyositis possesses with certain other connective tissue diseases, namely Lupus Erythematosis and Scleroderma which more commonly involve these viscera. *Second,* it reflects the possible common etiologic background of the connective tissue diseases, particularly in the light of their similarities at necropsy. *Third,* it suggests that connective tissue has only a limited way in which to express any given insult. Banks[32] quite

clearly projected this general view in 1941 when he wrote, "The widespread visceral involvement in each is obscured by certain dominating focal manifestations, which serve as the clinical basis for the differentiation of these syndromes from each other. Striking similarities, however, in the detailed pathology of these various conditions require evaluation for a possible relation or common denominator among them."

Summary

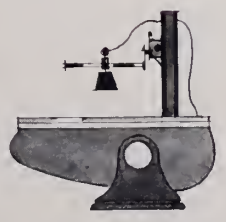
A 39 year old negro male with extensive visceral involvement, whose basic disease was polymyositis, is described. Unusual clinical features were the transient azotemia, albuminuria, pericarditis, atrial fibrillation, and pulmonary radiographic changes developing during the acute phase of myopathy. Signs of renal disease by blood chemistry studies showed a trend to improvement before prednisone was begun, and completely cleared four months after the initial symptoms of myopathy occurred. Chest x-ray revealed parenchymal infiltration and effusions on admission without respiratory symptomatology. The lung fields cleared radiographically in 5½ months. A pericardial friction rub developed and persisted for four weeks while the patient was taking prednisone. Two transient episodes of atrial fibrillation were documented during the first six weeks of hospitalization.

The patient's disease remitted in 5½ months and he was able to resume heavy labor. However, remission lasted only 4 months, and from this subsequent exacerbation he never completely recovered. Multiple small pulmonary emboli caused his death 22 months after the initial attack of myositis.

A synopsis of the patient's post-mortem findings is included. The observed cardiac, pulmonary, and renal involvement in polymyositis is reviewed from published reports.

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Total Lateral Wall Duodenal Fistula†

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Total lateral wall duodenal fistula occurring from postoperative complication or from post-traumatic duodena; injury is not a common problem. The patient's preparation and nutritional status should be at an optimum before repair is contemplated. A side-by-side duodenojejunostomy with a distal jejunojejunostomy is satisfactory for treatment of this problem.

A TOTAL lateral wall duodenal fistula is a duodenal wall defect through which the entire gastric, biliary, and pancreatic content become diverted from the gastrointestinal tract. (Fig. I) Conservative treatment by continuous drainage and suction of an end-duodenal fistula followed by spontaneous closure has been proved to be the treatment of choice from past experience. Total lateral wall duodenal fistula presents a different situation, requiring surgical intervention at a selected time, depending on the patient's general condition. The occurrence of a total lateral wall duodenal fistula is secondary to duodenotomy or to trauma. Pancreatitis, infection, operative technique and the patient's general condition are etiological factors causing duodenal fistulization following duodenotomy. Total fistulization depends on the degree of lateral wall defect and/or whether distal mucosal protrusion and serosal contraction causes partial distal obstruction.

The purpose of this paper is to present a case of total lateral wall duodenal fistula associated with pancreatitis, following duodenostomy, and its management.

†*Read before Kentucky Surgical Society, French Lick, Indiana, May 13-14, 1966.*

**Reprint requests to Surgical Section, Lexington Clinic, Lexington, Ky.*

Case Report

A 64 year old man was admitted to the hospital on December 18, 1963 with progressive upper abdominal pain radiating to the back. As he had a past history of duodenal ulcer, antacids had been used by the patient before admission but without relief. Examination revealed only tenderness in the epigastrium. Laboratory data included total bilirubin 2.15 mg.%, amylase 273 units and alkaline phosphatase 11.8 units. A gallbladder series revealed no function and a GI series was within normal limits. Preoperative diagnosis was chronic cholecystitis, cholelithiasis and chole-

FIG. I

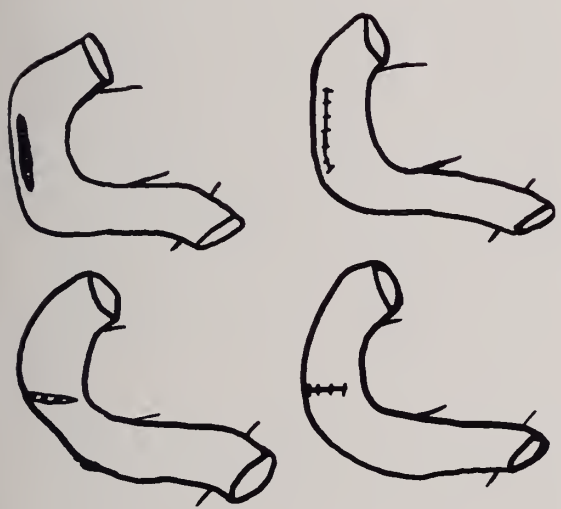


END FISTULA TOTAL FISTULA

docholithiasis. A cholecystectomy, common duct exploration with T-tube drainage and transduodenal sphincterotomy for removal of an impacted ampullary stone was done on December 21, 1963. On the fourth postoperative day the patient's pulse rate increased to 110 per minute and his temperature rose to 103° F in 24 hours. Moderate thin gray drainage with pancreatic odor was noted about the penrose drains. The patient became confused. Procaine penicillin 400,000 units and streptomycin 0.5 grams had been given twice daily since the operation. Terramycin 500 mg. intravenously twice daily was added and procaine penicillin was increased to 1,000,000 units every six hours. A serum amylase was 144 units.

Despite nasogastric suction the patient was moderately distended and quite tender in the right upper quadrant. Repeated cultures revealed Klebsiella. On the eighth postoperative day dark blood was noted coming from the nasogastric tube. All antibiotics were discontinued and Cephalothin 4 grams daily was started. His hemoglobin was 12 grams, WBC 24,000 with 9$_0$ polys, bilirubin 4.15 mgm.%, alkaline phosphatase 4.9 units and SGOT 93 units/ml. Serum electrolyte determinations

FIG. II



DUODENOSTOMY CLOSURE

were within normal limits. Because of the decreased hemoglobin of 9.8 grams and as the patient was vomiting blood the diagnosis of stress ulcer was entertained. After 1,500 cc. of whole blood was administered the patient was explored on his 13th postoperative day. A fulminating pancreatitis with duodenotomy closure dehiscence and extensive digestion of the lateral duodenal wall were the major findings. Sump pump drainage and a feeding jejunostomy were established. During the operative procedure and postoperatively the patient was hypotensive, with 60 to 80 mm. mercury systolic pressure, requiring Neo-Synephrine®, Levophed® and blood replacement to keep the blood pressure in this range. It was possible to discontinue vasoconstrictors after 48 hours. Drainage was copious, requiring 4,000 to 6,000 cc. of the appropriate replacement and maintenance fluids daily. Because of a paralytic ileus, tube feedings were not successfully started until the ninth postoperative day. Repeated electrolyte determinations were within normal limits. Four attempts to mobilize the patient to an upright position on his twelfth to fifteenth postoperative day resulted in profuse hemorrhage from the drain site and hematemesis which produced shock requiring transfusions on each occasion. Over the next several days weight loss was approximately 60

FIG. III



TEXTBOOK DUODENOSTOMY

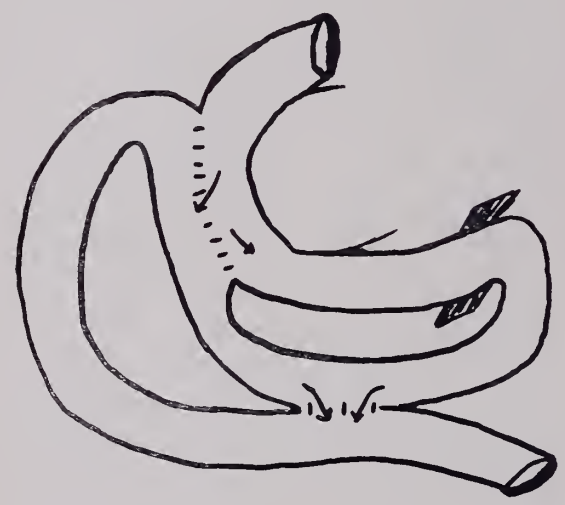
pounds. After repeated transfusions, high protein tube feedings with Viokase and the drainage collected from the patient's fistula and intravenous fluids, his general condition improved. On February 21, 1964 (eighth postoperative week) a duodenojejunostomy, jejunojejunostomy and tube gastrostomy were done. The jejunal feeding tube was finally removed on April 8, 1964 after oral feedings had been gradually increased over the previous four weeks. An upper gastrointestinal series revealed the anastomosis to function well and the T-tube cholangiogram was within normal limits. Two years later the patient is asymptomatic and weighs within five pounds of his pre-illness weight.

Discussion

Duodenotomy was a very useful procedure in removing an impacted ampullary stone in this case. The closure of a longitudinal duodenotomy incision in a transverse manner has been recommended in many surgical texts. Anatomically a transverse closure of a longitudinal incision in the lateral or anterior wall of the duodenum appears to be incorrect.[1] The medial wall of the duodenum is held rigid by the

head of the pancreas and it is possible that a transverse closure can give a degree of tension on the suture line. Rarely, if ever, is the duodenal diameter so small that a careful two or three layer closure would critically narrow its lumen. A longitudinal incision and transverse closure technique does not appear to present this type problem in other areas of the small bowel and colon. It appears that either a transverse or a longitudinal incision of the duodenal wall with a closure in the same direction is a more anatomical procedure. (Fig II and III)

FIG. IV



JEJUNODUODENOSTOMY

JEJUNOJEJUNOSTOMY

The term, total lateral wall duodenal fistula, is used in this case because the findings during the second operative procedure revealed eight to ten centimeters of loss of continuity in the lateral duodenal wall, sparing one third to one half of the medial duodenal wall. Initial attempts to close the remaining wall about a large T-tube were unsuccessful as the tissue was too friable to hold sutures.

Maintenance of nutrition in a patient with a total lateral wall duodenal fistula is a perplexing problem. Because of the amount of electrolytes and fluid volume lost through a fistula of this type, a jejunal feeding tube and an intravenous polyethylene catheter are required for the administration of necessary calories, electrolytes, vitamins and enzymes. The collected drainage from the fistula can be used at appropriate times and is reintroduced into the small bowel by the way of the jejunal feeding tube. A Berman pump is a very helpful device in continuous food feeding administration but it is not necessary as an adequate and steady drip of tube feeding was kept going in this patient for many days.

A technique of serosal patch to close a lateral duodenal fistula has been reported.[2] A duodenal wall defect of the size reported in this case cannot be closed primarily. A Roux-Y limb could not be fashioned in such a way to result in closure. A side-to-side duodenojejunostomy with a distal entero-enterostomy to prevent circus movement of food appears to be the most anatomical arrangement giving a mucosa to mucosa anastomosis and reducing the possibility of stricture or failure of the anastomosis to heal. A necessary length of jejunal opening on the antimesenteric border is made so as to encompass the fistula. As the serosa of the medial duodenal wall retracts after long standing fistulization, the entire circumference of the defect has to be dissected free in order to have an inverted mucosa to mucosa anastomosis. (Fig IV)

Summary

The problem of total lateral wall duodenal fistula has been presented. Before a definite surgical repair of the fistula is contemplated, the nutritional status of the patient should be optimum. A side to side duodenojejunostomy with a distal jejuno-jejunostomy is recommended for closure of a large lateral wall duodenal fistula.

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April 19 - 20

KMA Interim Meeting

Ken-Bar Inn, Gilbertsville

Volvulus of the Proximal Colon And Small Intestine Produced By A Giant Leukosarcoma: Report of a Case and Review of the Literature

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Louisville, Kentucky

This report emphasizes the significance of early surgical extirpation of localized lymphomas wherever possible. It illustrates a very unusual and serious abdominal emergency due to a huge lymphomatous mass.

ROKITANSKY in 1827 was the first to describe volvulus of the colon, which he at that time called "intestinal strangulation." This entity is less frequently seen in the United States and Canada compared to Eastern European, Asian, and African countries. The proximal colon and small bowel are less frequently affected than the sigmoid colon. Volvulus of the cecum is an anatomically incorrect description, because it is unlikely and uncommon that the proximal ascending colon is not involved in this process. Volvulus of the proximal colon is responsible for approximately 2% of all intestinal obstructions, 10% of all colonic obstructions, and 32% of all intestinal volvuli. (R. Wilson)

Uhlenhuth and Hendrik in a study on cadavers (at the University of Maryland School of Medicine) made the assessment that in 22% of the males and 28% of the females, the proximal colon was sufficiently mobile to permit it to be rotated 180° or more.

Causes

The precipitating factors in acute or recurrent volvulus of the proximal colon and small bowel are:

1. A redundant proximal colon due to loose or absent ligamentous attachments or failures of the final fixation of the gut after its rotation in the fetal stage.
2. Postoperatively, most frequently after appendectomy or right ureterolithotomy, when the cecum has been mobilized to facilitate removal of the appendix or stone. Postoperative adhesions and bands can also produce the volvulus.
3. Obstruction due to tumors of distal large bowel, adhesions, intussusceptions, hard feces, large mesenteric cysts or tumors, large foreign bodies intraluminally, chronic constipation, and aganglionic segments of colon as in congenital megacolon.
4. Dietetic habits as among the Eastern European, Indian, and African people where there is usually a large amount of roughage in the diet (Figiel and Figiel), as well as malnourishment, resulting in a long thin mesenteric pedicle.
5. Miscellaneous causes, such as violent cough, purgatives, pressure and displacement due to a gravid uterus.

The high mortality rate associated with this disease (in acute volvulus 42%, and when the cecum is gangrenous, 72%, Donhauser and Atwell) is mainly due to the delay in diagnosis, operation, and the association of systemic diseases.

Leukemia is characterized by the unrestricted proliferation of leukocytes or closely related

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cells or their precursors in hemopoietic and non-hemopoietic tissues. Virchow was the first to recognize the lymphatic and splenic forms of the disease. Pseudo-leukemia was the title which Cohnheim gave to the visceral manifestations of the disease in the absence of a typical leukemic blood picture. Sternberg suggested the use of the term Leukosarcoma for those cases of lymphosarcoma in which there was an associated leukemic blood picture as in the case which will be discussed later. These tumors usually attain large size and produce sequelae, such as obstruction, bleeding, intussusception, and volvulus.

Tumors that primarily arise in the mesentery and invade the intestinal wall later are usually liposarcomas, lymphosarcomas, angiosarcomas, and fibrosarcomas. In a study of several series of cases of volvulus, leukemia and its closely related lesions in the mesentery and intestinal tract, it was found that there was no instance of volvulus of the proximal colon and small intestine secondary to leukemic aggregation. The tumor we are reporting arose in the mesentery and invaded the ascending colon, ileum, and distal jejunum. The relative ratio of malignant lymphomas to that of all other malignant tumors encountered in the different segments of the gastrointestinal tract was 0.2% in the esophagus, 2% in the stomach, 39.7% in the small intestine, 0.5% in the colon, and 0.1% in the rectum. (Allen et al)

Diagnosis

Patients with volvulus have the tetrad of cardinal symptoms of intermittent, crampy abdominal pain, nausea, vomiting, and constipation. The association of systemic disease will give variable symptoms. Some patients have a history of previous volvuli. Some of them will give a history of appendectomy in the past.

The most constant physical finding is abdominal distension, developing very rapidly. Many times the abdomen is asymmetrically distended by an eccentric tympanitic mass. If the cecum is gangrenous, patients are usually in shock. Temperature, pulse, white blood count, and other laboratory data will vary with the duration, nature, and associated diseases, or precipitating factors.

A plain x-ray of the abdomen, including an upright view, is often diagnostic. The cecum is characteristically displaced and dilated to



FIGURE 1. Plain x-ray of the abdomen shows an enormously distended right colon filling almost the right half of the abdominal cavity. Note that there is very little evidence of air in the rest of the gastrointestinal tract. The wall of the right colon is well delineated by the air inside and the free fluid in the peritoneal cavity. A striking feature in the film is the homogenous density masking other details.

enormous proportions. If the cecum is distended and displaced to the left upper quadrant, it may be mistaken for the stomach. A large subdiaphragmatic abscess with air and fluid levels will often make radiological distinction difficult. Barium enema will demonstrate the abrupt tapering ("bird beak deformity") of the colon, distal to the volvulus.

Case Report

L. W. P., a 65-year-old white female, was seen at St. Thomas Hospital, Nashville, Tennessee, on July 1, 1965, with complaints of cramping, abdominal pain, nausea, vomiting, constipation and marked abdominal distension. She had been acutely ill for over 24 hours. She had had no previous surgery. In July, 1964, she was found to have a huge abdominal mass, nodes in the axilla and groin, and marked pallor. W. B. C. was 41,600 with 94% lymphocytes. She received a course of nitrogen mustard and blood transfusions at another local hospital with some improvement. In December, 1964, the nodes and the abdominal mass had further enlarged, and her total W. B. C. was 855,000 with 99% lymphocytes. She received 1,500 r's of cobalt therapy over the

abdomen. Her total W. B. C. dropped to 26,-500, and she did well.

On admission to the hospital, she was markedly dehydrated, pale, and her abdomen was tremendously distended. Hb. 10.8, P. C. V. 31, total W. B. C. 24,600 with 75% lymphocytes. Platelets were 146,000. VDRL, non-reactive. Urine showed 1+ protein, 2-4 W. B. C. and 4-8 R. B. C. Plain film of the abdomen showed a dilated and displaced cecum and a large homogenous density. Nasogastric suction and parenteral fluids with massive doses of antibiotics were started. Two hours after admission she was explored through a long right paramedian incision. There was a moderate amount of ascitic fluid. The tumor mass filled the abdominal cavity from the costal margins to the pubic symphysis; and it had turned over, producing torsion of the mesentery of the small bowel and the whole right colon. Spleen and liver appeared to be normal. The tumor was a friable, soft, huge mass that bled very easily. There were several 1-3 cm. size lymph nodes elsewhere in the mesentery and retroperitoneal area. The tumor was resected along with about 12 feet of strangulated distal small intestine. The torsion of the cecum was relieved, and it looked viable so a cecopexy was done. Her blood pressure was unstable from the beginning of the procedure. She received a total of 3,000 cc. blood. She went downhill very rapidly and expired six hours after surgery. We were unable to obtain an autopsy to evaluate the extent of the disease in the mediastinum or brain.



FIGURE 2. This photograph shows the size of the lesion in relation to the abdominal cavity. The right colon has been retracted to display the relation of an uninvolved segment of the small bowel (right upper quadrant) and the involved segment of the small bowel emerging from the tumor (left lower corner).

Pathology

The tumor was a large homogenous mass of pinkish tan color, with occasional areas of hemorrhages. The total weight of the tumor was 3,400 Gm. The tumor arose in the mesentery of the distal small bowel and had invaded the wall of the intestine. The mucosa of the intestine was intact.

Microscopically it contained closely packed, small lymphocytes, diffusely infiltrating the tissues. The findings were compatible with small cell lymphosarcoma or leukemic infiltration of lymphatic leukemia.

Discussion

In contrast to the variegated appearance of the leukocytes in myeloid disease, the blood smear of lymphatic leukemia is featured by a marked predominance of small mature lymphocytes and only a very small number of immature nucleated forms. Involvement of bone marrow in chronic lymphatic leukemia is patchy but progressive until there is confluence of the lymphocytic foci. Platelets are generally unaltered until the marrow becomes usurped by leukemic lymphoid tissue. A normocytic type of anemia is generally present in these cases. Splenomegaly is not very striking in chronic lymphatic leukemia, but lymph nodes attain large sizes. Visceral infiltrates diffuse or nodular and tumor-like in character may involve any organ in the body.

Lymphatic leukemia is generally looked upon as a generalized systemic disease in the territory of the internist, hemotologist, and radiotherapist for treatment. But in a few cases localized lymphomatous lesion may be amenable to surgery. There are no valid reasons for assuming that these lesions are all systemic from their inception even though at a later date most cases develop systemic manifestations, when the chances of cure or palliation are remote. This opinion was confirmed by the findings in a large series of autopsies in which it was noted that over 10% of the lesions would have been amenable to surgery, (Gall and Mallory). Smith and Klapp treated 54 patients with localized lymphoma (25% of all lymphomas seen during 1948-1960 at George Washington University Hospital). Of the 31 undergoing operations, 22 were alive and well at the end of five years, whereas only 2 out of 23 treated with x-ray alone were alive at the end of five years. Rose studied 17 cases



FIGURE 3. This view clearly demonstrates the torsion on the mesenteric pedicle and part of the circumference of the right colon and some loops of the small bowel. At the periphery of this large lesion which weighed 3,400 Gms., there were a few satellite lesions, much smaller in size.

with lymphoma of the lung and found a 45% five-year survival rate after surgery. All the others who could not be operated upon and were treated with irradiation were dead in twelve months. There is evidence that irradiation may sometimes stimulate the invasive phase of the disease, since the change from non-leukemic lymphosarcoma to lymphosarcoma cell leukemia has been found to follow rapidly after radio-therapy. (Kato and Brunschwig)

Biggs and Elliott collected 14 cases of leukemic involvement of the gastrointestinal tract from the literature, and in those cases pain, diarrhea, and weight loss were the main symptoms. The largest leukocyte count in any of their cases was only 20,000/cm. An abdominal tumor other than spleen was felt only in five cases. The only two abdominal emergencies they reported from the leukemic involvement were intussusceptions. Hersh et al reported in their series one case of a large dural tumor. Hyman et al found some correlation between leukemic patients with blood group A and the incidence of carcinoma of the colon and rectum. They made a strong plea to investigate the patients with leukemia and blood group A, to rule out malignancies of the lower gastrointestinal tract. It was noted that there



FIGURE 4. Microscopically, the closely-packed lymphocytes with generalized and uniform infiltration of the tissues are typical of small cell lymphosarcoma. The serosal layer of the intestine showed a similar infiltration, but the mucosa was intact. This patient's blood picture also showed a picture of chronic lymphatic leukemia.

was a significantly increased incidence of hemorrhages (72%) in leukemic patients who were on steroid therapy. (Hersh et al)

Surgical Treatment

Relieving the torsion and ascertaining the viability of the involved bowel is the first step while exploring one of these patients. If the bowel is viable, cecopexy, colopexy, or appendicostomy or cecostomy are the frequently-used procedures. Simple reduction has never been a satisfactory treatment. Dixon and Meyer described a more stable procedure ("cecocoloplicopexy") by burying the cecum under a peritoneal flap raised from the lateral peritoneal wall. If the colon does not appear viable, a right hemicolectomy should be undertaken without hesitation. Before the days of antibiotics and satisfactory anesthesia, exteriorization of the involved bowel was an accepted mode of treatment.

Adjuvant Therapy

After localized lymphatic tumors have been completely or incompletely resected, it is ad-

visable to give these patients some form of adjuvant therapy. External radiation, radioactive phosphorus, triethyline melamine, and nitrogen mustard are available for use. Unfortunately, the therapeutic doses of TEM and nitrogen mustard are close to the toxic levels. (Wintrobe et al) External radiation is the most effective and least toxic of these measures.

Summary

A rare manifestation of chronic lymphatic leukemia producing a surgical emergency has been presented. A brief review of the historical backgrounds of volvulus and chronic lymphatic leukemia with their usual clinical manifestations has been made. Localized lymphomatous lesions should be radically resected wherever possible to avoid the late sequelae, systemic manifestations, and complications. By a more aggressive approach, we may be able to enhance the five-year survival rate in selected cases. The surgical correction of volvuli of the proximal colon and the medical adjuvant therapy of such problems if associated with lymphomatous lesions have been enumerated.

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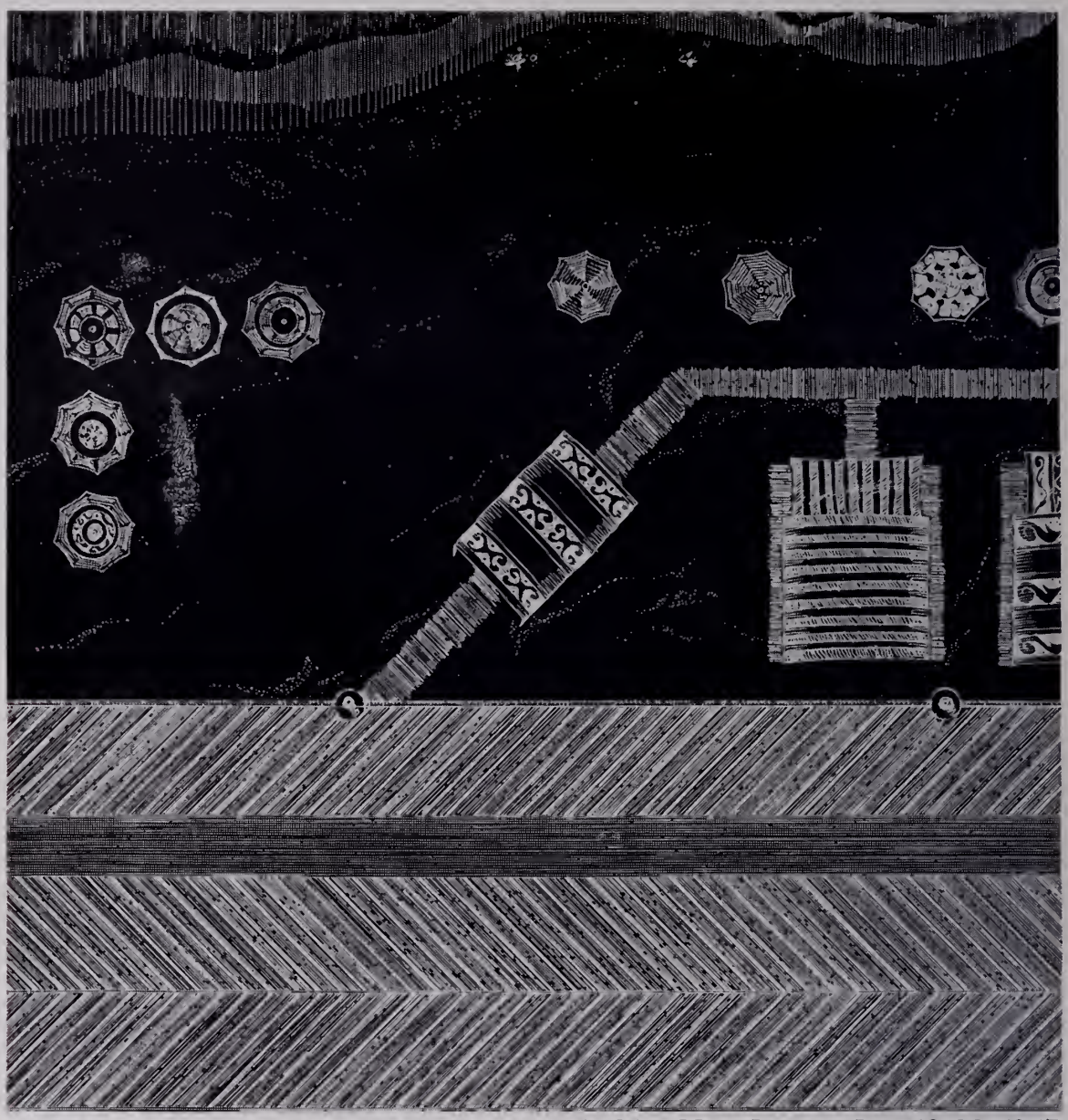
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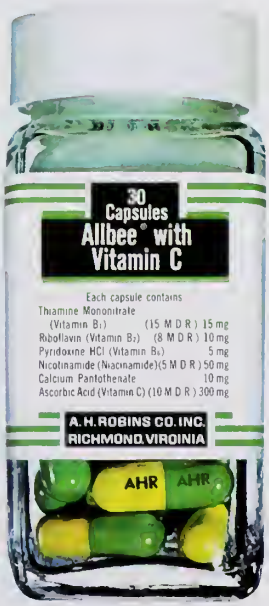
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Can The Best Be Better?†

WALTER H. JUDD, M.D.*

MY first reaction to the question, "Can the Best Be Better?" was to say "yes" and sit down, while still ahead. The pursuit of excellence is a part of the spirit and tradition of America, and particularly of our profession. We instinctively feel that the best can always be made better.

My second reaction was one of at least fleeting concern as to the apparent immodesty of a public declaration that the medical profession is the "best". Physicians are expected to assume this fact, but is it in keeping with the "honor and dignity" of the profession to make a public point of it and to make comparisons which might seem to reflect unfavorably on other professions?

So, we must first ask, *is* the medical profession the "best"? We were taught to examine a patient before making a diagnosis. Sometimes we have been so preoccupied, and properly, with our shortcomings — both those that are real and those not real but attributed to us in much of the public mind — that the picture can be seen in perspective only if we consider, at the outset, the bright and positive side also.

For generations medicine has been commonly referred to as "queen of the professions".

In March, 1964, the National Opinion Research Center, an affiliate of the University of Chicago, published a paper entitled "Occupational Prestige in the United States: 1925-1963". Of some 90 occupations that of "physician" was rated most desirable of all except Justice of the United States Supreme Court. Two professions in which I was temporarily engaged, Representative in Congress and college professor, were in a tie for eighth place. Diplomats, chemists and lawyers were tied for tenth place. Dentists, architects and county judges were tied for the fourteenth most desirable, with psychologists and ministers tied for seventeenth.

Additional evidence as to the relative status of the medical profession is found in a study of the Missouri Bar by Prentice-Hall published in 1963. It reported:

> "Members of the legal profession are seriously concerned not only with their reputation in the community but with how their profession compares with other professions. Laymen may feel that lawyers are 'great' but when they compare lawyers with say medical doctors, lawyers become a little less than great".

May I add that much self-appraisal by the lawyers enhances rather than reduces their greatness. I hope we will do as well.

I. A record of Progress and Achievement

To the extent that not only we but other professions and the public as a whole rate the profession of medicine as the "best", why should this be so?

The ten principles of Medical Ethics provide, I believe, the basic reasons. They are the blueprint and the foundation stones on which medicine's house has been built. Both the principles and the accomplishments of the profession can be broken down into three categories: (1) the science of medicine; (2) the socio-economics of medicine; and (3) the art of medicine. Let us review the present record of progress and achievement in each of these areas, even though I realize I am like the preacher who is about to exhort those already converted.

A. *The Science of Medicine*

It is a well established ethical concept that every physician should aid in safeguarding the public and the profession against admission to it of those who are deficient in moral character, education, or professional competence. How well has the profession met its responsibility to attract applicants of quality?

In 1905, 28 per cent of all college graduates were entering the field of medicine. This situation prompted President Gilman of Johns Hopkins to remark that the medical student was likely to be "one son of the family too weak to labor on the farm, too stupid for the bar and too immoral for the pulpit". At that time only five medical schools required as much as two years of college as a prerequisite for matriculation. Today, the Admission Committees of our 88 schools require at least three years and almost all strongly recommend the completion of four years of college or its equivalent.

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†*Address delivered by Doctor Judd at the President's Luncheon, during KMA's Annual Meeting in Louisville, September 21, 1966.*

**Walter H. Judd, M.D., is a former Congressman, a member of the AMA Judicial Council, and a nationally known author and lecturer.*

In 1964-65, there were 19,200 applicants for 8,800 first-year positions.

It is a fact that the cream of our youth has been attracted to the medical profession and the problem is not so much one of screening out undesirables as it is of making wise decisions in selecting from those who are already the "best", the ones who have the best character, best minds, best aptitudes, best motivations.

In order to make certain that there is no insurmountable economic barrier to admissions, the medical profession has supported scholarships and loan funds. Notably, the AMA in 1962 launched its medical education loan guarantee program which now has made 27,000 loans totaling more than $32 million to medical students, interns and residents.

The medical profession has taken the lead in securing the enactment in the states of Medical Practice Acts, Basic Science Acts and in supporting the state boards which administer them. It has established a National Board of Medical Examiners to prepare and administer qualifying examinations of high quality. It has also established the Educational Council for Foreign Medical Graduates to verify the credentials, evaluate the educational qualifications of foreign-trained physicians, and assist those who desire to advance their education in the United States.

The body of knowledge with which the medical profession deals has unquestionably expanded further and faster within the past 30 years than that of any other profession. For example, about 90 percent of the biomedical scientists in all of history are alive and working today. Seven out of ten prescriptions today are for drugs not even known in 1950. In 1960 approximately 40,000 professional health workers were engaged in medical and health-related research. It is estimated that by 1970, their number will be almost doubled.

The medical profession has been equally diligent in making the new knowledge available to its members and to students. Today, each of the 88 medical schools in the United States has voluntarily met the high standards established by the Liaison Committee on Medical Education.

It is particularly interesting to note that all this has been accomplished without the use of any "authoritarian" powers: the mere reporting of fact to the schools and to the public has resulted in the virtual disappearance of substandard medical education in the United States. Currently fourteen additional medical schools are being formed and each is deeply indebted to the Liaison Committee for its counsel and assistance in developing fully acceptable facilities.

The medical profession has recognized for years that instruction in medical school is only a prelude to a lifetime of striving for ever-greater competence in the care of the sick. Thirty-seven of our fifty states require the completion of approved internship and there is a yearly increase in residency training in the several specialties. Nor does medical education stop at this point or with the stiff requirements for certification in the various specialties. The numbers of continuing education courses for physicians has increased almost fifty per cent in the past five years. There has been a marked increase in attendance at these courses and standards and procedures for a formal program of accreditation of such courses has been approved by the AMA's House of Delegates.

An editorial in August 9, 1965 issue of The Journal of the American Medical Association notes:

> "The formal courses are only part of the story. Registration at the scientific meetings of all medical organizations continues to climb. Hospital staff meetings, journal clubs, clinico-pathological conferences, therapeutic conferences, radiological conferences, and scientific lectureships abound. Medical education programs on radio and television networks reach the physician at his hospital, his office, and his home. Automatic film projectors and programmed instruction provide ready access to self-instruction in the leisure hours. And physicians probably still get most of their medical knowledge from medical journals, books, abstracts, and monographs, as the flood of the printed word continues to rise."

The hospital and nursing home constitute another important area in which much has been done to improve the quality of medical service. It is my impression that the public has little conception of the work of the medical profession and the American Hospital Association in carrying out today's well-established program for accreditation of hospitals.

Although the "policing" actions of hospital medical staffs are well known to you, I venture to say that the public generally is unappreciative, because unaware of the manner in which physicians voluntarily, as members of a hospital staff, impose requirements on themselves to insure a high quality of medical service, to grant privileges according to ability, to supervise and to accept supervision, to review critically the handling of specific cases and to require adequate record keeping. It is not the government, it is the medical staff that has always been and is the guardian of the high quality of medical service rendered in our hospitals.

Another principle of Medical Ethics is:

> "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle."

Even though the unceasing efforts of the medical profession to combat unscientific and unsound methods of healing invariably results in attacks on it and its motives, the profession has consistently, and at times heroically, withstood these attacks and maintained active programs designed to protect the public from charlatans, quacks and cultists.

When has any profession ever worked so hard to reduce its own income by eliminating or reducing the incidence of the diseases and suffering which it is the physician's livelihood to treat? This brings us to the socio-economic aspects of the practice of medicine and the record of the profession in this field.

B. *The Socio-Economics of Medicine*

The explosion of scientific knowledge within the past 30 years burst upon a profession prepared by tradition and training to anticipate, to receive, and to use that knowledge. The profession was not pre-

pared, either by tradition or training, for the explosion in the socio-economic fabric of our society. The physician was accustomed to intimate doctor-patient relationship without the intervention of any third party. Three decades ago problems concerning the distribution of medical services were comparatively minimal. Today they are monumental. Not withstanding these considerations — and despite the abuse that has often times been directed at the medical profession because it did not embrace various schemes proposed for the intervention of third parties in the doctor-patient relationship — there is much accomplishment in this area.

The profession has aided in the development of voluntary health insurance and prepayment plans as the best mechanism for paying for medical and hospital care. It has supported and cooperated with numerous programs at all levels of government designed to provide medical services to those who would not otherwise be able to obtain them. It has aided governmental programs for veterans, military personnel and their dependents and federal employees. Currently, it is studying various proposals for postpayment of medical bills to determine whether, operating under suitable safeguards, they too may reduce economic barriers to maximum health care.

It has generally maintained physicians' charges at fair and reasonable levels. According to the 1964 Report of the Commission on the Cost of Medical Care, physicians' fees had risen only 112 percent since 1935 as compared with 123 percent in the over-all cost of living, 136 percent in the total cost of medical care, and 480 percent in hospital daily service charges.

The physician continues to observe the ethical guidelines that "his fees should be commensurate with the services rendered and the patient's ability to pay" and that "poverty of a patient * * * should command the gratuitous services of a physician." On the average, today's physician spends about one-eighth of his time in providing free care. In 1960, physicians donated approximately $658 million in free medical care.

The medical profession has supported and will continue to support a diversity in the financing of health care by cash, prepayment and insurance, or postpayment and taxes. But it insists, and surely it should insist for the sake of the patient, that no payment plan interfere with or impair the free and full exercise of the physician's medical judgment and skill or tend to cause a deterioriation in the quality of medical care.

> The tenth Principle of Medical Ethics provides: "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community".

Let me recall to you, just by naming them, some of the areas vitally affecting our people's well-being in which the profession has played a leading, often the decisive role: maternal and child care; public health and immunization; alcoholism; automotive safety; medical aspects of sports; rehabilitation of disabled; mental health; disaster medical care; aerospace medicine; occupational health; school health; environmental health, including air and water pollution; food and nutrition; cosmetics, drugs; and many others.

Only when putting all these facts together for this paper did I myself appreciate the magnitude and comprehensiveness of medicine's achievements here as well as in science. That is why it has seemed to me important to recite the highlights of the record. Can any other profession surpass it?

C. *The Art of Medicine*

May I group here those Principles of Medical Ethics which emphasize personal care of the patient and relationships between physicians.

These ethical guidelines may be summarized as follows:

> "The principal objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Fees should be fair. Unnecessary services or unnecessary facilities should not be provided or prescribed. Confidential communications between physician and patient should be respected. There should be mutual free choice between physicians and patients in entering into the doctor-patient relationship. A patient should neither be neglected nor abandoned. The physician should neither exaggerate nor minimize the gravity of a patient's condition. One physician should do nothing to diminish the trust reposed by a patient in his own physician. Physicians should uphold the honor and dignity of the medical profession and expose 'without hesitation, illegal or unethical conduct of fellow members of the profession.' There is but one code of ethics for all, be they group, clinic or individual and be they great and prominent or small and unknown".

There is, of course, no accurate yardstick by which the degree of compliance with these Principles may be measured, particularly those dealing with the physician's personal attention to his patient and his relations with the fellow-physicians. I, for one, am of the opinion that most of these principles are more wholeheartedly honored and observed by the profession today than ever before. Present public opinion obviously believes some are less well observed today than in former years. Undoubtedly this opinion is influenced in part by a nostalgia which magnifies the virtues of the past and also the shortcomings of the present as reflected in the isolated cases which come to public attention.

Yet we know that in our profession — as in others — there does exist a minority that must be controlled or disciplined if the moral tone of the profession is to be maintained at the highest level. This is the negative approach to medical ethics, but it is necessary and must be pursued courageously. That the medical profession is well aware of this fact is evidenced in part by the creation of a Medical Disciplinary Committee which undertook a comprehensive survey to determine whether satisfactory disciplinary mechanisms exist and whether they are

being effectively used. The majority of its recommendations has already been adopted.

The latest annual report published in the Journal of the American Medical Association (December 21, 1964) compares disciplinary actions by state boards of medical examiners with disciplinary actions in the legal profession and notes a striking similarity. The two professions are of approximately equal size. For the last four years in which figures are available for the legal profession (1959-1962), 313 attorneys were disbarred. This compares closely with 319 physicians who lost their licenses in the four-year period (1960-1963).

Disciplinary actions reported by state boards of medical examiners and state medical societies are, of course, only the visible part of the iceberg and give no indication of the volume of formal or informal grievance and disciplinary proceedings that occur each year. As you well know, most complaints against physicians are and should be handled by the physician himself in consultation with the complaining patient. When this does not bring satisfaction, or when the patient does not take his grievance directly to his physician, complaints are made to county and state medical societies and occasionally to the AMA, which invariably refers them back to the county medical society for attention. It is at the local level that all but a few of the more serious cases are handled, grievances resolved and discipline imposed — usually without publicity.

Because medical society membership is so valuable and therefore coveted, the only sanction available to medical societies — that of expulsion or suspension from membership — is highly effective in most instances. In those cases in which the offender is not a member of a medical society, it may be necessary to resort to sanctions authorized by state law. The well-known Medical Disciplinary Act in the State of Washington can serve as a model for those other states whose laws require strengthening if the medical profession is to have greater authority to deal with the minority of physicians who are guilty of unethical conduct or improper practices.

II. Some areas for Further Improvement

While the record of the medical profession justifies our feeling that it is the "best", we need to consider now some areas in which greater progress and improvement should be made.

A. *The Science of Medicine*

First, with respect to the so-called shortage of physicians. Even though ten new medical schools have been created since World War II and an additional fourteen are in process of being organized, the medical profession has a continuing obligation to take the lead in making certain there is always an adequate supply of properly-trained physicians to meet the needs of the public, both present and projected.

B. *The Socio-Economics of Medicine*

It is obvious that the profession should try even more aggressively to propose and promote ways and means of meeting any public need for better distribution of medical services — always within the Principles of Medical Ethics, particularly the Principle that:

> "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

The profession has an obligation to apply this Principle in the same objective, scientific way in which medicine is practiced — that is, with prudence and yet with imagination. The public should be made more aware of the basic interest it has in proper application of this Principle. Only such an awareness can immunize against the propaganda that medicine's motives are more political or economic than ethical and professional.

I also suggest greater realism in dealing with the relationships of ethics to economics. It is the first and fundamental Principle of Medical Ethics, "The principal objective of the medical profession is to render service to humanity" which truly makes medicine a noble calling, steeped in service and altruism. But that does not mean that the compensation of the physician is of no consequence or that it is "noble" to disregard it.

Expectation of reward and financial return in accordance with one's merit and effort are a powerful incentive to a physician, as to anyone else, to broaden his skills, improve his service, do his utmost for his patient. It is the public that has most to gain from provision of such incentives. They do not cheapen medical practice; they can elevate and enhance it. Unless medicine can remain attractive financially as well as in other ways, it will not attract the quality of students it must have if it is to do what the public needs and wants from it.

Another problem in the economic area is that posed by the application of the 7th of the Principles of Medical Ethics which provides:

> "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients".

Under this Principles come those vexatious problems of physician dispensing of drugs, eye glasses, etc., physician ownership of pharmacies and drug repackaging companies, and the problem of fee splitting. It is in this sensitive area, particularly, that substance is more important than form — that the spirit must go beyond the letter. The medical profession has been challenged by legislation already enacted and the threat of additional legislation concerning the ownership of pharmacies and the dispensing of glasses. Although many of these attacks may be motivated more by economic than by ethical considerations, they cannot be ignored.

The medical profession must review the exceptions it has made to the 7th Principle. These exceptions permitted drugs, remedies or appliances to be dispensed or supplied by the physician "provided it is in the best interest of the patient" and "provided there is no exploitation of the patient". The clear intent of the Principle is indicated in the latest interpretation (1963) which overrides any previous interpretation

and which states that the language of the exceptions quoted above "does not authorize him (the physician) to dispense solely for his convenience or for the purpose of supplementing his income". Unless the medical profession can obtain compliance with the spirit as well as the letter of these exceptions, it will be haunted by some continuing unsavory examples of exploitation of the patient and therefore, of unethical conduct. And it will invite, probably ensure, the sort of punitive action by governmental agencies that will damage the profession far more than the gain for a few of its members can possible offset. Some practices that may be legal are still unbecoming and unworthy of so great a profession.

C. *The Art of Medicine*

This brings us finally to those less tangible Principles of Medical Ethics which pertain to physician-patient and physician-physician relationships — "The Art of Medicine". In what ways can the best be made better here?

Let us consider first the negative aspect of medical ethics — medical discipline. The 1961 Report of the AMA Medical Disciplinary Committee stated:

> "The results of the study show that, by and large, adequate medical disciplinary mechanisms do exist and that they are used. The frequency and effectiveness of their use however, are less impressive. There has been a failure, in some areas, to act promptly, impartially, and objectively when the necessity arises."

Obviously grievance and disciplinary mechanisms are valueless if they are not used. And clearly, there is room for improvement at this point.

In general, such procedures should be therapeutic — not punitive. The two extremes of "witch-hunting" on the one hand and apathy and buck-passing on the other must be avoided. Alert, positive, prudent and judicial action in utilizing grievance and disciplinary procedures at all levels is required if the honor and dignity of the medical profession are to be maintained at the highest plane.

The challenge of the moment is to stimulate fresh attention by the individual physician to medical ethics in order that he may make the principles more relevant and meaningful in his professional life. I recognize that ethics and morality grow best from within and cannot be superimposed externally. I do not hold to the corollary view, however, that ethics is a purely personal matter and that the individual physician is entitled to complete privacy in this area. Even deeply religious persons find it important to devote time to corporate as well as to individual worship. By the same token, all physicians, including those of the greatest integrity, can profit from group consideration of those basic principles which constitute the fabric of the professionalism of medicine.

I recognize that, in general, "men of good conscience inherently know what is right and wrong, and what is to be done or to be avoided." But it does not follow that all ethical questions are so clear that men of good conscience will invariably agree on the proper answer.

Physicians have understandably been so preoccupied with the challenge of the scientific and socio-economic developments of the past quarter of a century — and by the pressing demands of patient care — that there has been, almost of necessity, a neglect of emphasis and interest in the area of true professionalism. Moreoever, the temper of the times has not been conducive to idealism. I think I detect signs, however, which indicate an awakening of interest by our society in matters of ethical and moral conduct. It is too early at this stage to predict that the pendulum is beginning to swing back in an era which has seen even the Good Samaritan sometimes passing by on the other side of the road and which has been marked by an abnormal degree of public indifference to fraud, evasion and callous self-dealing. Is it possible for any profession — including the "queen of the professions" — to buck the tide of public morality when that tide is running out rather than in?

Doubtless recognition of these problems is a reason for your inviting a person like me to discuss them with you. Leaders of the profession like yourselves, physicians of exemplary integrity and public-spiritedness need to think together, exchange experiences and viewpoints and find inspiration and motivation to rededicate a great profession at the peak of its powers to its finest traditions and its finest ideals.

A renaissance in the professionalism of medicine is needed — something that will grip individual practitioners all over the country and cause them to restudy and reaffirm, in the light of their own insights and the challenge of today and the years ahead, those ideals and traditions which in the past have always set the practice of healing apart?

It is not enough just to refrain from behaving *unethically*. The profession needs a new pride, a new enthusiasm-for-excellence in the high duties entrusted to it that will make every physician want to behave ethically in the highest sense of the word, to go beyond the things required by rules or regulations — for the sheer satisfaction and joy of it.

The medical profession has grown great in this country because it has merited public trust and confidence — a trust and confidence which have led to its being given by our people a monopoly in the management of the most intimate concerns they have — their life and their death. Medicine has been given a relatively free hand to regulate and govern itself, because both the profession and the public interest have been better served thereby.

But one cannot fail to see a serious challenge to the profession's freedom in the activities we witness in various quarters designed to persuade the people that their trust and confidence in medical matters would be better placed in government than in the profession. Unless the profession can win this competition of the primary confidence of the people, and maintain and strengthen the people's trust, it runs the grave risk of being converted into a public utility subject to the sort of regulations that are imposed on transportation, communications and power.

The medical profession has enemies that it would be a mistake to regard as men of good will. On the other hand, not all of our critics have sinister or selfish motives. Some are within our own ranks and are seeking to stimulate the medical profession to rededicate itself to those principles which have made

it peerless. The friends of medicine are legion — people who want a sign from physicians that they are as true to their ideals now as ever. The people want to have affection for and trust in their doctors. With this trust firmly established, medicine in 1966 will not have passed or even reached its zenith. It will be able and will be permitted to go on to new heights of accomplishments and service.

On the other hand, failure to measure up to our responsibilities could mean the beginning of a decline in the standing of the profession that means so much to all of us — a decline which would not end during your lifetime and mine.

Medicine is not alone in this struggle. Lawyers, ministers, dentists, engineers, architects and many others have more in common with us than they or we have realized in preserving professionalism as a vital part of American life. All professionals and the public alike must be constantly reminded of the important distinctions between a profession and a business, a trade or a union. It is essential for America's greatest future that a worthy medical profession remain free and strong, free practitioners of a high calling, not government-directed technicians. The key to this result is to merit and to command public trust and confidence. This does not come in the bargain basement. It must be deserved and it must be striven for. Its price, like that of liberty, is eternal vigilance. The key is in your hands. Take it home and unlock the doors to the future.

Can the "best" be better? The first answer is still "Yes, it can be." The more complete answer is, "Yes, it must be" — must be made better, each year and by us, if those values so dear to us, so vital to our patients, and so essential to our society — are to survive.

May my last paragraph be the substance of the last paragraph of our oath. The wisdom of the immortal Hippocrates 2,300 years ago is relevant today:

"With our oath unviolated
it will be granted to us
to enjoy life
and the practice of the art
respected by all men
at all times".

Make Arrangements Now

To Attend the

1967 Interim Meeting

of the

Kentucky Medical Association

April 19 and 20 **Gilbertsville, Ky.**



The Millis Report

In the early part of the century the American Medical Association requested a study of undergraduate medical education in this country, which resulted in the well-known Flexner Report. The favorable effects of that report on medical education are known to most physicians. New standards and new criteria were recommended and accepted, and undergraduate medical education was vastly improved, and as a consequence medical care improved.

Since the Flexner Report there has developed a system of graduate medical education which includes the internship and the residency. It is now a common occurrence for the physician to spend a longer period of time in the educational period after graduation than he did as an undergraduate medical student.

At the present time the many internships and residencies that exist vary widely in their educational value. It is evident that the internship year is often regarded as a separate event and there in no effort at correlating that educational year with the residency years that follow or the undergraduate years that proceeded.

The AMA recognized that an overall study of graduate medical education was needed and to carry this out appointed the Citizens Commission on Graduate Medical Education, with John S. Millis, President of Western Reserve University, as Chairman. The Commission was composed of outstanding physicians and eminent citizens outside of the medical profession. After a three year study, the Commission made its report available at the end of 1966.

The recommendations of the Commission, if carried out, promise to affect the education of future physicians to a very large degree. The report could be the basis of another favorable revolution in medical education as was the Flexner Report.

The Millis Report, as the Commission's report has come to be known, emphasizes that medicine exists to serve society and must be responsible to society's demands. It is in response to changing medical and social events that the Commission makes it recommendations. Among some of the recommendations are those that urge the medical profession to train more physicians and to render comprehensive, continuing health services, including preventive measures. This type of physician is called a primary physician in the report. It is also urged that greater emphasis be given to the training of physicians for cooperative efforts between the primary physician, medical specialists and allied health professions. It is believed that the patient often will benefit from this type of cooperation.

It is recommended by the report that the internship, as a separate entity, be abandoned and that the internship and residency years be combined into a single graduate medical education experience. The graduate medical education period of training for the physician would be comparable in length of time to the other medical specialties.

At the present time the different phases of graduate medical education are under the control of a variety of societies, specialty boards, departments of hospitals, medical schools and the Council on Medical Education of the AMA. In order to obtain a better means of review, coordination and improvement of graduate medical education, the Commission recommends that the medical profession establish a new body which would be called The Commission on Graduate Medical Education.

It is suggested that all members of the new Commission would be appointed by the Council on Medical Education. Of the ten initial members of such a commission, it is proposed that three come from a list suggested by the Association of American Colleges and two

from a list suggested by the National Academy of Sciences. Responsibility for overseeing the whole area of graduate medical education would rest with the new Commission on Graduate Medical Education.

To implement all of the recommendations of the Citizens Commission on Graduate Medical Education would be a difficult and involved task. However, there does exist the tremendous challenge to the medical profession to bring up to date, to improve and to better coordinate graduate medical education. The Report will serve to stimulate thought and action in this direction.

WALTER S. COE, M.D.

Keep the Change?

ONCE again, on January 1 of this year, the ground rules for medical care have changed. This happened pretty quietly, without Sturm or Drang—chances are that none of us, at midnight December 31 when we mulled over 1966 and gave a qualified welcome to 1967, thought a great deal about Phase Two of Medicare. We have, since then, heard a good deal about it, and some few of us have become involved in it directly, through our patients' care. But to most of us "Extended Benefits" is more a phrase than a Phase, to date. I submit that it can be an extremely powerful phrase, however, destined to do nothing less than to help change the basic pattern of American medical care.

What does "Extended Care" do? It makes available "funds for convalescent or restorative care, in specialized institutions or parts of institutions, to all Medicare participants. It also makes available funds for home health care, above and beyond the funds already available to pay the physicians, if such care is rendered by an agency approved for such service" (falling into this category are such services as visiting nursing, physical therapy, social service, and the use of various medical appliances). What does "Extended Care" *not* do? It does *not* cover the type of patient now occupying most of our nursing home beds—custodial care is "out", convalescent care is "in".

To the time of this writing, in mid-February, 27 nursing homes and 1,192 beds have qualified under this program in Kentucky, and each of these institutions is required "to have a transfer agreement with a hospital, a utilization plan and a disaster plan. Each patient must be under a doctor's immediate care, with admission certification and recertification requirements similar to those now used for hospital care. Each Home Care program must be under the supervision of a physician". There's no avoiding it—we as physicians are going to be involved in this part of Medicare, too. And as we become involved I think we may find this part generally to be not too bad a piece of legislation, in spite of our (at least, my) basic disagreement with the social philosophy that produced it.

For the Extended Benefits part of this law takes effect now at a time when there is tremendous demand for hospital beds, and it may have the practical effect of easing the pressure on hospitals and nursing personnel. But its real importance, I believe, will lie in its tendency to re-orient the public concept of medical care, helping to change the focus—from the hospital toward the home, from the medical center toward the community, indeed from sickness toward health.

Many other factors appear likely to reinforce this trend, and such a development will of course take some time, but if such a basic change does come about, with its renewed emphasis on the individual physician's relationship to his patient, and the patient's relationship to his home environment, it would seem to be, on the face of it, quite an acceptable one. Because neither legislation's effects nor social trends are predictable with any real precision, we shall, with a healthy skepticism, have to wait and see.

WALTER I. HUME, M.D.

PUBLIC HEALTH PAGE

Heart Disease Activities †

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

A FAMILY physician in a rural Kentucky community has a six months old patient with congenital heart disease but is unable to make a definitive diagnosis. A physician in western Kentucky has a coronary patient who is not recovering as he should and would call in a consultant if the patient could afford it. A physician in the mountains sees children with rheumatic fever but their parents cannot afford the prophylactic drugs which will prevent a recurrence of the illness. The Heart Disease program of the State Health Department was actively designed specifically to assist each of these physicians and their patients.

During the past year physicians over the state have referred more than 1,475 children and adults to special diagnostic and evaluation clinics jointly sponsored by the State Health Department and the Kentucky chapter of the American Heart Association. They usually cover a five or six county area and meet annually or semi-annually depending on the case load in the area. During the current fiscal year 39 such clinics have been scheduled.

In the eastern part of the state the clinics are staffed by a team from the University of Kentucky Medical School which includes a cardiologist and a pediatric cardiologist. In the western half of the state two teams from the Medical School in Louisville conduct separate clinics for children and adults. Any person referred by his physician as an indigent patient will be accepted at the clinics.

Following the clinic each referring physician receives a report containing the diagnosis and recommendations of the cardiologist. If catherization and/or surgery is recommended social workers on each team assist in making arrangements for these procedures. In many instances all or part of the cost is borne by other agencies such as the Crippled Children's Commission or Vocational Rehabilitation.

In addition to the clinics the Heart Disease Program sponsors and administers a program to provide prophylactic drugs to victims of congenital heart disease, rheumatic fever, and rheumatic heart disease. In this program the physician writes a prescription for the drugs and sends it to the county health department. Within a few days the patient will begin to receive the medicine and will continue to receive it as long as his physician desires.

Currently the medicines available and the doses recommended by the American Heart Association's Committee on the Prevention of Rheumatic Fever and Bacterial Endocarditis are:

Benzathine Penicillin G, injectable Tubex
1,200,000 units once a month
Buffered Penicillin G, 250,000 unit tablets
one or two tablets per day
Sulfadiazine, 0.5 gram tablets
one or two tablets per day

At the end of last December nearly 7,600 persons had received medicine under this program at some time since its inception in the late 1940's. Approximately 3,500 of these patients are currently receiving medicine and the list continues to grow by 600 names per year.

As in the clinic program, the only eligibility requirement is referral by a practicing physician. The Health Department does, however, expect the physician to make periodic re-

(Continued on Page 310)

†*This article was prepared by Donald Austin, M.D., Office of Chronic Disease, Kentucky State Health Department, Frankfort.*



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas



ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

ABBOTT

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mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

New from Du Pont

Symmetrel®

(Amantadine HCl)

The first oral chemical virostat for the prevention of influenza A_2



Influenza virus
Protein shell enclosing the core of nucleic acid (RNA)—artist's representation

The incidence of influenza A_2. In this country, where influenza is one of the leading causes of morbidity, influenza A_2 (Asian) continues to be a serious medical problem. In 1957 influenza A_2 was responsible for approximately 40,000 excess deaths in a three-month period. Since that year the most prevalent influenza virus has been A_2 (Asian).

What is Symmetrel®? "Symmetrel" (amantadine HCl) is a new synthetic chemical which acts as a molecular barrier to virus penetration. It provides for the first time specific oral medication for the prevention of respiratory infections caused by influenza A_2 (Asian) viruses—an entirely new approach in preventive medicine.

For prescribing information, see last page of this presentation

What Symmetrel® (amantadine HCl) means to you

...the first and only oral chemical agent to prevent influenza A_2 (Asian).

...not a vaccine or antibiotic, but a new synthetic chemical unrelated to any other chemotherapeutic agent.

...unique mode of action: prevents virus penetration of the host cell without affecting vital cell functions.

...specifically active against all influenza A_2 viruses tested to date.

...not indicated for the prevention of influenzal or respiratory illness other than influenza A_2 or for the treatment of established disease.

...does not interfere with normal antibody response; acts in concert with pre-existing antibody.

What Symmetrel® means to your patient

...possible immediate influenza A_2 protection when taken following suspected contact.

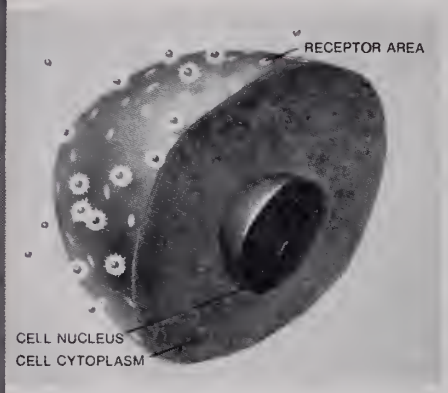
...may be particularly useful during outbreaks or epidemics and for high-risk patients in whom the occurrence of influenza A_2 is especially hazardous.

...a high degree of safety in clinical use.

...simple once daily or b.i.d. dosage.

The mode of action of Symmetrel®

How the influenza virus invades and destroys the untreated cell



1 Viruses outside the cell attach themselves to specific cell receptor areas

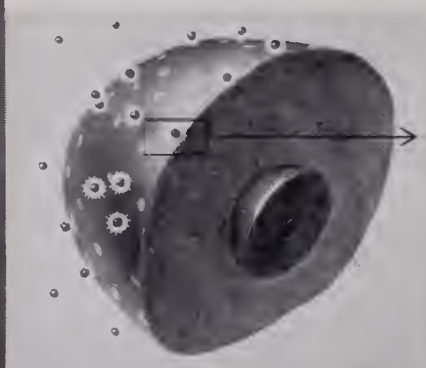


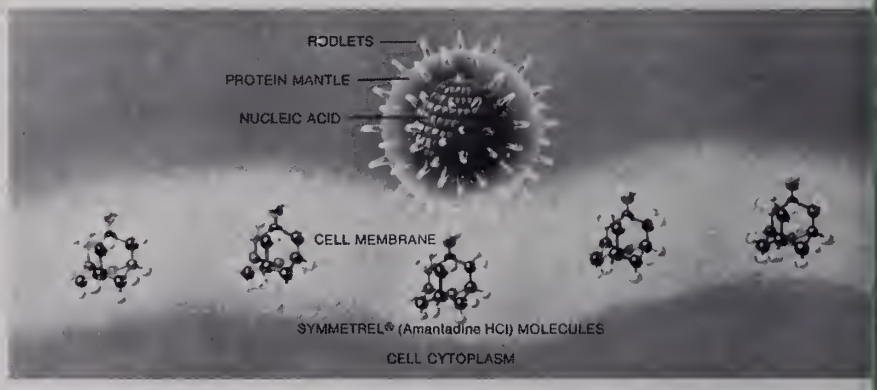
2 The virus is incorporated into a vacuole within the cell. From this vacuole the virus nucleic acid passes into the cell cytoplasm



3 The virus nucleic acid then directs the cell to produce both new virus nucleic acid and virus protein coat material which aggregate to form new virus particles. This process leads to the release of new virus particles and eventual destruction of the cell

How Symmetrel® (Amantadine HCl) prevents virus invasion[1]





Our current knowledge leads us to believe "Symmetrel" acts as a molecular barrier to influenza virus penetration. Shown here in a greatly enlarged section, "Symmetrel"—located at the cellular membrane—effectively prevents (blocks) virus penetration. Thus, "Symmetrel" does not directly destroy the virus particle but acting as a virostat prevents the cycle of virus penetration, virus replication, and cell destruction that is characteristic of virus invasion of animal cells (tissue). *Artist's conception based on current scientific knowledge.*

1. "Mode of Action of the Antiviral Activity of Amantadine in Tissue Culture", Hoffmann, C. E.; Neumayer, E. M.; Haff, R. F.; and Goldsby, R. A., Journal of Bacteriology *90*,623 (1965).

afety of Symmetrel® Confirmed. When used as indicated, is generally well tolerated. No kidney, ver, bone marrow, or hematological disturbances have been observed.

rescribing Information

dications: "Symmetrel" is indicated for the preven- on (prophylaxis) of influenza A_2 in persons of all age oups. Early use is recommended, preferably before as soon as possible after actual or suspected con- ct with individuals suffering from influenza A_2. Symmetrel" should especially be considered for gh influenza-risk patient groups such as those suf- ring from chronic debilitating diseases and elderly rsons.

ntraindications: Not indicated for the prevention influenzal or respiratory illness other than influ- za A_2 or for the treatment of established disease.

arnings: Administration to patients with central rvous system disease, particularly geriatric patients ith cerebral arteriosclerosis, and patients with a story of epilepsy or other "seizures," requires strict bservation for possible untoward effects (see Ad- rse Reactions). Patients taking psychopharmaco- gic drugs, central nervous system stimulants, or coholic beverages should be observed for possible idence of intolerance. Those patients who experi- ce central nervous system effects or blurring of sion should be cautioned against driving or working situations where alertness is important.

No teratogenic effects have been seen in reproduc- e studies in rats and rabbits. Studies in pregnant omen have, however, not been done and use of this ug in women of childbearing age should be under- ken only after weighing the possible risks to the tus against benefit to the pregnant patient. It should t be administered to nursing mothers since it is not own whether the drug is secreted in the milk.

ecautions: Ineffective against bacterial infections. tients should be observed for idiosyncratic reac- ns as with all new drugs. Geriatric patients with e-existing serious medical illnesses with mental or ysical deterioration should be followed carefully edically while taking "Symmetrel." (See Adverse eactions.)

dverse Reactions: With higher than indicated doses anifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: *Adults:* Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: *Capsules:* Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.
Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.

DUPONT

Symmetrel®

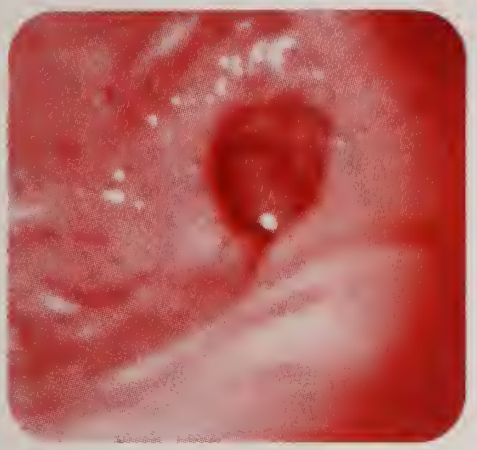
(Amantadine HCl)

A molecular barrier to virus penetration



NEW EVIDENCE:

Pro-Banthīne® (propantheline bromide)
gives positive, selective benefits in gastrointestinal disorders.



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg. of Pro-Banthine intravenously.

AN IMPORTANT PROBLEM in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthine does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthine intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthine is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Contraindications: In glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

SEARLE *Research in the Service of Medicine*

When the battle with bacteria is in the upper respiratory trac

Routes of invasion through the oral and nasal passages to the nasopharyngeal mucosa: artist's depiction of sagittal section of head in perspective.



consider Gantanol (sulfamethoxazole)



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Before prescribing, please consult complete product information, a summary of which follows:

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first three months of life.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions, including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus or rickettsial infections.

Adverse reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets b.i.d. or t.i.d. depending upon severity of infection. Children—1 tablet/20 lbs initially, followed by ½ tablet/20 lbs b.i.d.

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POST-GRADUATE SYMPOSIUM ON RHEUMATIC DISEASES

Rankin Amphitheater **APRIL 20, 1967** Louisville General Hospital

SPONSORED BY THE KENTUCKY ARTHRITIS FOUNDATION
AND THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

TOPIC: OSTEOARTHRITIS AND RELATED DISORDERS

This symposium is designed to present a comprehensive review by authorities of the new and fundamental knowledge related to the various aspects of osteoarthritis and certain associated disorders.
Emphasis will be given to a consideration of the current theories of etiology and pathogenesis, clinical features, radiologic manifestations with attention to new techniques, rehabilitative applications, and advances in medical and surgical methods of managing this common rheumatic disease. Panel type discussions with questions from the audience will supplement the series of lecture presentations.

GUEST FACULTY:

NATHAN R. ABRAMS, M.D.: Associate Clinical Professor of Medicine, University of Cincinnati College of Medicine; Director of Arthritis Clinic, Cincinnati General Hospital, Cincinnati, Ohio

GLENN M. CLARK, M.D.: Professor of Medicine and Chairman of Division of Rheumatology; Assistant Dean in Charge of Hospital Affairs and Chief of Staff, City of Memphis Hospitals, University of Tennessee, Memphis, Tennessee

WILLIAM S. CLARK, M.D.: President, The Arthritis Foundation, New York City

ROBERT H. FREIBERGER, M.D.: Director of Department of Radiology, Hospital for Special Surgery; and Associate Clinical Professor of Radiology, Cornell University Medical College, New York City, New York

EDWARD E. GORDON, M.D.: Chairman of Department of Physical Medicine and Rehabilitation, Michael Reese Hospital and Medical Center, Chicago, Illinois

THEODORE A. POTTER, M.D.: Associate Professor of Orthopedic Surgery, Boston University School of Medicine; Chief of Orthopedic Surgery, Robert B. Brigham Hospital, Boston, Massachusetts

LEON SOKOLOFF, M.D.: Chief of Section on Rheumatic Diseases, Laboratory of Experimental Pathology, National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Maryland

U. OF L. FACULTY:

Frank W. Lehn, M.D. David H. Neustadt, M.D. Donn L. Smith, M.D. Beverly T. Towery, M.D.

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FOR FURTHER INFORMATION CONTACT KENTUCKY ARTHRITIS FOUNDATION, 209 SPEED BUILDING, LOUISVILLE, KY. 40202

ORGANIZATION SECTION



Pictured above is Ken-Bar Inn, scene of the 17th Annual KMA Interim Meeting, April 19 and 20. This new resort, located in Gilbertsville, is well suited to house the Interim Meeting, providing a large number of facilities and varied attractions.

Problems Facing the Profession Today to Highlight Program of KMA Interim Meeting in Gilbertsville—April 19-20

Some of the most pressing problems facing the medical profession—including medical manpower, financing medical care, and political action—will be explored by five nationally known authorities at the KMA Interim Meeting in Gilbertsville on April 19 and 20, according to Robert E. Pennington, M.D., London, KMA president.

Doctor Pennington urged all members to take advantage of this opportunity to discuss mutual problems and to hear expert opinions in the fields of vital concern to the profession today.

The complete program of the two-day 17th annual Interim Meeting at Ken-Bar Inn was released by Doctor Pennington at press time. (See page 293)

Featured speaker at the dinner which will kick-off the meeting on Wednesday evening will be Charles B. Shuman, president of the American Farm Bureau Federation who will speak up for the free enterprise system in a talk entitled, "We Are Winning".

On Thursday morning speakers will include: Paul I. Hoagland, M.D., Pasadena, Cal., "Not in Mediocrity, But in Leadership"; William J. Lewis, Jr., M.D., Dayton, Ohio, "Working to Win"; and Joseph F. Volker, D.D.S., Ph.D., Birmingham, Ala., "The Impact of Federal Legislation on Medical Practice, Education, and Research".

F. J. L. Blasingame, M.D., Chicago, Ill., executive vice president of the AMA, will discuss, "A Profession United" at the luncheon session which will close the meeting.

Doctor Hoagland's career reflects his interest in the economics of medical care. He served on the board of the National Association of Blue Shield Plans from 1962 until assuming the presidency of the NABSP in 1966.

A member of the board and past chairman of the Board of Trustees of California Physicians Service, he is also a past president of the California Society of Internal Medicine and a founder member of the American Society of Internal Medicine. Doctor Hoagland received his M.D. degree from Stanford in 1938.

Doctor Volker, vice president for Birmingham Affairs and director of the University of Alabama Medical Center, will discuss problems related to medical manpower. He served as a consultant to the

(Continued on Page 394)

Program

KMA 1966 Interim Meeting

Ken-Bar Inn, Gilbertsville

April 19 and 20, 1967

WEDNESDAY EVENING SESSION

Robert E. Pennington, M.D., Louisville, President
Kentucky Medical Association, presiding

5:00 p.m. Registration
6:30 p.m. Dinner, Barkley Room
7:30 p.m. Call to Order, Doctor Pennington
7:40 p.m. "We Are Winning"—Charles B. Shuman, Chicago, Ill.

THURSDAY MORNING SESSION

Doctor Pennington, presiding
Grand Rivers Room

8:45 a.m. Registration
9:15 a.m. Call to Order and Announcements
9:30 a.m. "Not in Mediocrity, But in Leadership"— Paul I. Hoagland, M.D., Pasadena, Cal.
10:00 a.m. "Working to Win"—William J. Lewis, Jr., M.D., Dayton, Ohio
10:30 a.m. Coffee Break
10:45 a.m. "The Impact of Federal Legislation on Medical Practice, Education, and Research" — Joseph F. Volker, D.D.S., Ph.D., Birmingham, Ala.
11:15 a.m. Question and Answer Session
12:15 p.m. Recess for Lunch

LUNCHEON SESSION

12:30 p.m.
George F. Brockman, M.D., Greenville
KMA President-elect, presiding

Invocation, Rev. B. J. Barron, Methodist Church, Calvert City
"A Profession United"—F. J. L. Blasingame, M.D., Chicago, Ill.
Adjournment


Mr. Shuman


Dr. Hoagland


Dr. Lewis


Mr. Volker


Dr. Blasingame

University of Kentucky on the development of its medical center.

A former dean of Tufts College Dental School and the University of Alabama School of Dentistry, he received his dental degree from Indiana University and a Ph.D. in biochemistry from the University of Rochester in 1941. Doctor Volker is a member of the National Advisory Council on Education and the Health Professions of the Public Health Service and the National Advisory Commission on Health Manpower (President's Committee).

Biographical information on Doctor Blasingame appeared in the January issue of *The Journal* and Mr. Shuman and Doctor Lewis were featured in the February Journal.

The site of this year's meeting was chosen because of the excellent recreational facilities in the area and it is hoped that physicians and their families will take advantage of them during the long week end following the meeting.

Adjuncts to the meeting will be a New Member Orientation Program on April 19 and a meeting of the KMA Board of Trustees.

4th KMA Orientation Course Ken Bar Inn, Apr. 19

The fourth KMA Orientation Course for new members will be held April 19, 1967, at Ken Bar Inn, Gilbertsville, just prior to the opening of the KMA Interim Meeting. The course is conducted semi-annually in conjunction with each Interim and Annual Meeting.

The KMA Bylaws provide that new members are required to attend such a program and are given two years from the date of joining the association to do so. This session will be the fourth and final opportunity for a few new members while nearly 200 have completed the course previously.

The one-half day program is designed to better equip the new KMA member in meeting present day responsibilities as a citizen and a physician. Letters of invitation will be sent to those who have not attended a previous course while any KMA member is welcome to attend. The session will begin with registration at 12:30 p.m., CST.

MD Licensure Registration Delayed by Health Dept.

The State Department of Health, has informed the KMA Headquarters office that there will be a delay in the first annual registration of Kentucky physicians.

It was reported in the February Journal that annual registration would get underway early in February and completed on or before March 1.

It was reported by the department that a delay in the compilation of forms for the registration and procedures for distribution to physicians. KMA members are not expected to comply with the new regulations until the forms have been received, at which time more detailed information will be provided.

There is no fee for the registration nor is there any penalty involved. Since this is the first annual registration, it is now expected that it will take considerable time to get it into operation.

KEMPAC Urges MDs, Wives and Staff to Register & Vote

Kentucky will elect a governor, lieutenant governor, twenty state senators, one-hundred state representatives and other state officials in 1967. The May 23 primary will decide nominees for each party office.

Harold B. Barton, M.D., chairman of the Kentucky Educational Medical Political Action Committee urged all physicians, wives and staff to make sure they are legally registered to vote on May 23. He also urged that they get to know all those who are running for office, pick out the best candidate, and give that candidate their support.

He said he felt that the best way for medicine to make its voice felt is to work through KEMPAC.

New Medicare-Medicaid Form To Be Distributed Soon

The single form that was recommended by the KMA Technical Advisory Committee on Indigent Medical Care (Title XIX) for use by physicians in connection with claims filed by recipients under Title XIX who are also covered by physicians' benefits under Title XVIII of the Medicare Act, designated SSA 1490W (KY), has been approved.

According to Don Smith, Lexington, manager of the office of the Metropolitan Life Insurance Company, Carrier for Kentucky under Title XVIII, Part B, it is understood that the first 100,000 forms will be delivered to the Department of Economic Security in Frankfort for transmission to the physicians by mid-March.

An additional 300,000 will be shipped to both the Department of Economic Security and the Metropolitan for further distribution within sixty days or by the early part of April. It will be a three-part form permitting the physician to retain one copy with the original and first copy being forwarded to the Metropolitan.

After the interview with Mr. Smith, Commissioner Robert M. Ball reiterated this fact at the February meeting of the Jefferson County Medical Society.

James D. Crase, M.D., has closed his part-time office in McKee, devoting full-time to his office in Berea.

Top Speakers to Highlight 3rd Occupational Health Conf.

A number of outstanding speakers, including Governor Edward T. Breathitt and leading specialists in the field of occupational medicine, will highlight the program of the Third Kentucky Governor's Occupational Health Conference, April 6, at the Phoenix Hotel in Lexington.



Dr. O'Connor

Governor Breathitt is scheduled to give the opening talk of the day-long conference, which will be centered around the theme "Management's Role in Occupational Health and Safety."

Mr. G. S. Peppiatt, Detroit, Chairman of the Board of the National Association of Manufacturers will be the Keynote speaker for the morning session of the Conference. Other speakers featured during the morning session are: Dr. George M. Wilkering, Chief of Industrial Hygiene and Safety, Bell Telephone Laboratories, Maryhill, New Jersey; Richard A. Prindle, M.D., Chief of the Bureau of Disease Prevention and Environmental Control, U. S. Public Health Service; and Robert B. O'Conner, M.D., Pittsburg, Vice President, Health Services, U. S. Steel Corporation.

Doctor O'Conner, who graduated from Harvard Medical School in 1939, is active in various organizations, including: the Industrial Medical Advisory Boards of the American Association of Industrial Nurses, the President's Committee on Employment of the Handicapped, and the National Association of Manufacturers.

After lunch, Mr. George A. Jacoby, Detroit, Director of Personnel Relations, General Motors Corporation, will deliver the Keynote address for the afternoon session. Other speakers included in the afternoon program are: Dr. Marion Pearsall, professor, Department of Behavioral Science, University of Kentucky; and Miss Jane Lee (R.N.), Washington, D.C., Occupational Health Nurse Consultant, U.S. Public Health Service.

The sponsors of the program include business and labor organizations, the State Department of Health, the Universities of Kentucky and Louisville, and other interested parties.

UL Med. Alumni Plan Boat Ride

The University of Louisville School of Medicine Alumni are tentatively planning to get together on the "Belle of Louisville", Tuesday night, September 26, during the KMA Annual Meeting in Louisville. Leslie R. Shively, Director of Alumni Relations at U of L, said that chairmen for the ten reunions to be held this year will be announced at an early date.

University of Louisville classes planning reunions at the 1967 KMA Meeting are: 1917, 1922, 1927, 1932, 1937, 1942, 1947, 1952, 1957, and 1962.

Dr. Harris, Paducah, KMA Vice President, Dies at 46

James A. Harris, M.D., Paducah, KMA vice-president from the Western District, accidentally lost his life when a gun discharged in his home early in January.

Doctor Harris was a native of Grandfield, Oklahoma, and attended public school in Cincinnati, Ohio. He graduated from the Duke University School of Medicine in 1950, and was a diplomate of the American Board of Urology.

He was a Marine combat officer in World War II, and held the rank of colonel in the Marine Reserve. He practiced medicine in Lexington before going to Paducah six years ago.

ACS Group To Meet Apr. 27-29, Louisville Stouffer's Inn

The Annual Meeting of the Kentucky Chapter of the American College of Surgeons will be held April 27-29, 1967 at the Louisville Stouffer's Inn, according to David A. Hall, M.D., Lexington, Chapter secretary.

The program will be presented by the Department of Surgery of the University of Louisville. Guest surgeons from out of town have been invited to participate.

The honored guest of the meeting will be Ben Isman, M.D., who recently resigned as professor and chairman of the Department of Surgery of the University of Kentucky College of Medicine.

Glaser and Armstrong to Head Kentucky Allied Council

Mrs. Marjorie Glaser, R.N., President of the Kentucky Nurses Association, was chosen president of the Kentucky Council on Allied Medical Services at its January 25 meeting in Louisville. She will succeed Mr. Otis Wheeler, past president of the Kentucky Hospital Association, who has served the past two years as chairman.

Mr. Gilbert Armstrong, Director of Field Services for KMA, was elected secretary to succeed the late E. Murphy Josey of the Kentucky Pharmaceutical Association.

The Allied Council is made up of three representatives from the State Dental, State Hospital, State Nurses, State Pharmacy, and the State Medical Associations. Henry B. Asman, M.D., and Everett Baker, M.D., both of Louisville, along with the Executive Secretary, represent the KMA on this Council.

Leading Authorities in Ind. Med. To Head Program, April 22

Eight speakers, including the president of the National Industrial Medical Association will be featured at the April 22 meeting of the Kentucky Industrial Medical Association.

Walter L. O'Nan, M.D., Henderson, President-Elect of the Ky. Ind. Med. Assoc., said that the annual day-long spring meeting will be held in Louisville, at the Admiral Benbow Inn.

The Featured speaker will be J. F. McCahan, M.D., New York City, chief medical officer of A. T. and T. Long Lines.

Second Kentucky Diabetes Camp at Daniel Boone Aug. 6-19

The second Kentucky Diabetes Camp for children will be held August 6 to 19 at Camp Daniel Boone on the Kentucky River, according to R. J. Alberhasky, M.D., Louisville. camp committee member of the Kentucky Diabetis Assn.

The first Kentucky camp, held at Kentucky Lake last year, was regarded as very successful. In addition to other advantages of the camp, the children were able to learn much from attending physicians, nurses and dietitions.

The fee for the two week camping trip is $100.00 and this includes insulin and other special medications. Last year, according to Lewis Dickinson, M.D., president of the diebetes group, service clubs were able to finance the two-week stay at the camp for needy children.

The camp at Daniel Boone is being leased from the YMCA and is large enough to take care of both sexes.

Atlantic City Site of Annual AMA Meeting, June 18-22

Symposia of interest to both the generalist and the specialist will be included in this year's Scientific Program of the American Medical Association's Annual Meeting.

The Meeting will be held in Atlantic City June 18-22, the Scientific Progam in Convention Hall and surrounding hotels and the House of Delegates at the Chalfonte-Haddon Hall Hotel.

A Symposium on Absorption and Storage of Iron will be presented at a joint meeting of the Sections on Pathology and Physiology, Internal Medicine, Experimental Medicine and Therapeutics, and Gastroenterology.

KMA president, Robert Pennington, M.D., along with a good representation of KMA members are expected to attend the Annual Meeting.

The "Millis Report" and problems related to PL 89-97 will be among the matters of top interest to be considered in the House of Delegates.

UL Arthritis Group to Feature Eight Speakers, April 20

The University of Louisville School of Medicine, in cooperation with the Kentucky Chapter of the Arthritis Foundation, will sponsor a one-day Symposium on Rheumatic Diseases at Louisville General Hospital's Rankin Ampitheater on Thursday, April 20.

Included in the list of eight nationally recognized speakers is Theodore A. Potter, M.D., Associate Professor of Orthopaedic Surgery, Boston University School of Medicine.

The conference will cover Osteoarthritis and Related Disorders, and is open to all doctors, therapists and other professionals concerned with the Nation's number one crippler—Arthritis. Further information and registration forms may be obtained through the Kentucky Chapter, Arthritis Foundation, 209 Speed Building, Louisville.

UK Smith Lecturer, Dr. Prindle To Speak on Air Pollution

Richard Prindle, M.D., Washington, will deliver the second annual L. E. Smith lectureship at the University of Kentucky Medical Center on Wednesday evening, April 5.

Doctor Prindle, who will discuss "Air Pollution", is assistant Surgeon General in charge of the Bureau of Disease Prevention and Environmental Control.

L. E. Smith lectureships, at the state's two medical schools, are sponsored by the Kentucky TB and Respiratory Disease Association and local affiliates in memory of the late Doctor Smith, a leader in TB work in Kentucky. The lecture at the University of Louisville School of Medicine will be announced later.

Caring for Premature Babies, Program Held at UK

The next two-week special educational program in the care of prematurely born infants and other newborn who require special nursing care as a means of reducing infant mortality will be held May 15-26, according to a spokesman for the KMA Committee on Infant and Perinatal Mortality.

The program is offered specifically for nurses from the state of Kentucky and physicians, representing the hospitals of the nurse registrants, are invited to attend the last two days of the course.

The University of Kentucky Medical Center's Department of Pediatrics and College of Nursing sponsors the course in cooperation with the Division of Maternal and Child Health of the State Department of Health. For further information, contact Robert A. Beargie, M.D., Department of Pediatrics, U. of K. Medical Center.

Dr. Pellegrino, Guest Speaker At Ky. Thoracic Soc. Meet.

E. D. Pellegrino, M.D., dean and chairman of the Department of Medicine at the New York State College of Medicine, will be guest speaker at the spring scientific session of the Kentucky Thoracic Society, Thursday, April 6, at the University of Kentucky Medical Center, Lexington.



Dr. Pellegrino

Doctor Pellegrino formerly was professor and chairman of the department of medicine at the University of Kentucky College of Medicine. The day-long sessions begin at 8:00 A.M. with pediatric grand rounds featuring a case discussion of pulmonary problems in children.

"An Approach to Dyspnea" will occupy the 9:00 to 12:00 noon spot with clinical presentations illustrating airway disease and interstitial disease. This will include discussion with Doctor Pellegrino and Doctors J. E. Cohn, Lester Bryant and Pete Bosomworth.

The program is acceptable for six Prescribed hours by the American Academy of General Practice.

Kentucky Ob-Gyn Society To Feature Doctor Reis May 18-20

Ralph A. Reis, M.D., Chicago, will be the featured guest speaker at the Kentucky Obstetrics and Gynecology Society during its 1967 Annual Meeting in Lexington.

The dates for the meeting are May 18-20, and it will be held at the Continental Inn in Lexington, according to Francis A. Forde, M.D., President, Middlesboro.

Other speakers include C. Donald Christian, M.D., Durham, North Carolina, and Frank Peyton, M.D., Lafayette, Indiana.

Full details on the meeting will appear in the April issue of The Journal.

KEMPAC's Membership Growing

KEMPAC's membership is running considerably ahead of last year at this time. "The doctor is assuming an active, vital role in politics," according to Harold B. Barton, M.D., Corbin, Chairman of KEMPAC's Board of Directors. "This year's membership may run over last year's high of more than 800."

KEMPAC is Kentucky medicine's by-partisan political voice, Doctor Barton said. Its dual role is to help its members understand state and national political issues, and to organize them as an effective political action group.

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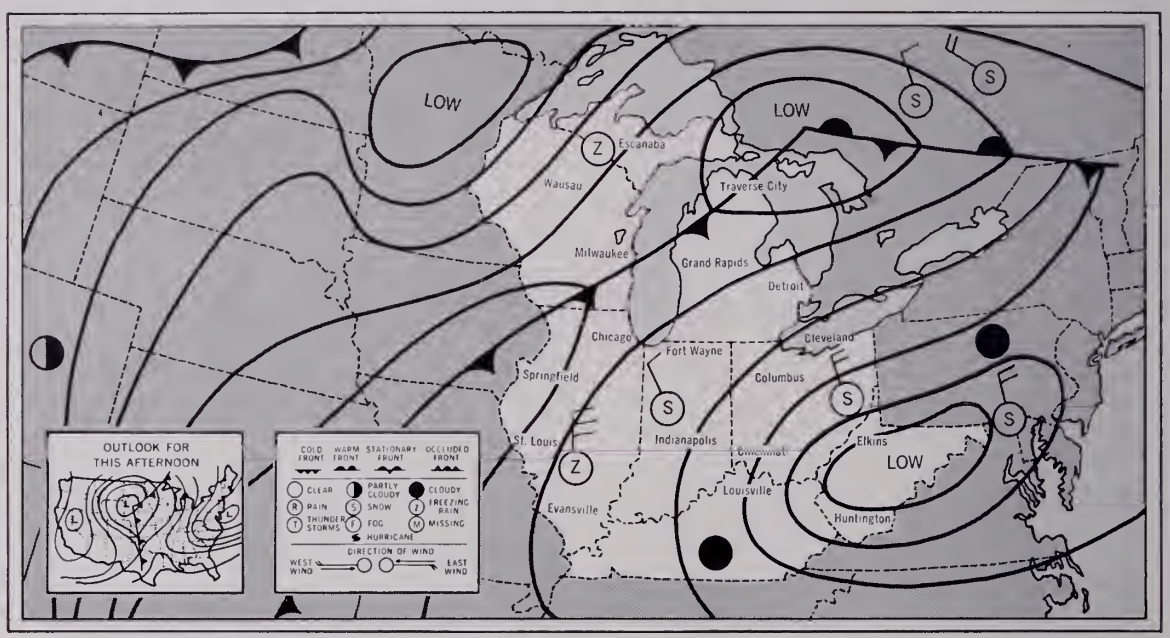
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KMA Announces County Medical Soc. Officers for 1967

KMA Headquarters Office has received, as of February 20, the following reports of County Medical Officers and Delegates for 1967:

Adair
- President: Oris Aaron, M.D., Columbia
- Secretary: W. Todd Jeffries, M.D., Columbia
- Delegate to KMA: M. C. Loy, M.D., Columbia
- Alternate: J. C. Salato, M.D., Columbia

Allen
- President: Earl P. Oliver, M.D., Scottsville
- Vice-President: John M. Hall, M.D., Scottsville
- Secretary-Treasurer: Owen L. Davis, M.D., Scottsville
- Delegate to KMA: Earl P. Oliver, M.D.
- Alternate: John M. Hall, M.D.

Bell County
- President: Francis A. Forde, M.D., Middlesboro
- Vice President: Adam Stacy, Jr., M.D., Pineville
- Secretary-Treasurer: Renfro F. Baird, Jr., M.D., Pineville
- Delegate to KMA: Meredith J. Evans, M.D., Middlesboro
- Alternate: Charles B. Stacy, M.D., Pineville

Boone
- President: Herbert R. Booth, M.D., Florence
- Vice-President: James Schrand, M.D., Florence
- Secretary: Floyd Poore, M.D., Florence
- Treasurer: Jack Ammon, M.D., Florence
- Delegate to KMA: James M. Huey, M.D., Walton
- Alternate: Glenn F. Baird, M.D., Florence

Bracken
- President: James M. Stevenson, M.D., Brooksville
- Secretary-Treasurer: D. E. Cummins, M.D.,
- Delegate to KMA: J. M. Stevenson, M.D. Brooksville
- Alternate: D. E. Cummins, M.D.

Clay
- President: J. L. Becknell, M.D., Manchester
- Vice-President: Ira Wheeler, M.D., Oneida
- Secretary-Treasurer: W. E. Becknell, M.D., Manchester
- Delegate to KMA: W. E. Becknell, M.D.
- Alternate: Ira F. Wheeler, M.D.

Crittenden
- President: James O. Nall, M.D., Marion
- Secretary: Richard M. Brandon, M.D., Marion
- Delegate to KMA: R. M. Brandon, M.D.
- Alternate: James O. Nall, M.D.

Cumberland:
- President: W. F. Owsler, M.D., Burkesville
- Vice-President: R. B. Chambliss, M.D., Burkesville
- Secretary: J. Schicknel, M.D., Burksville
- Delegate to KMA: J. Schicknel, M.D.
- Alternate: R. D. Chambliss, M.D., Burnesville

Floyd
- President: Frances R. Sherman, M.D., Martin
- Vice-President: George P. Archer, M.D., Prestonsburg
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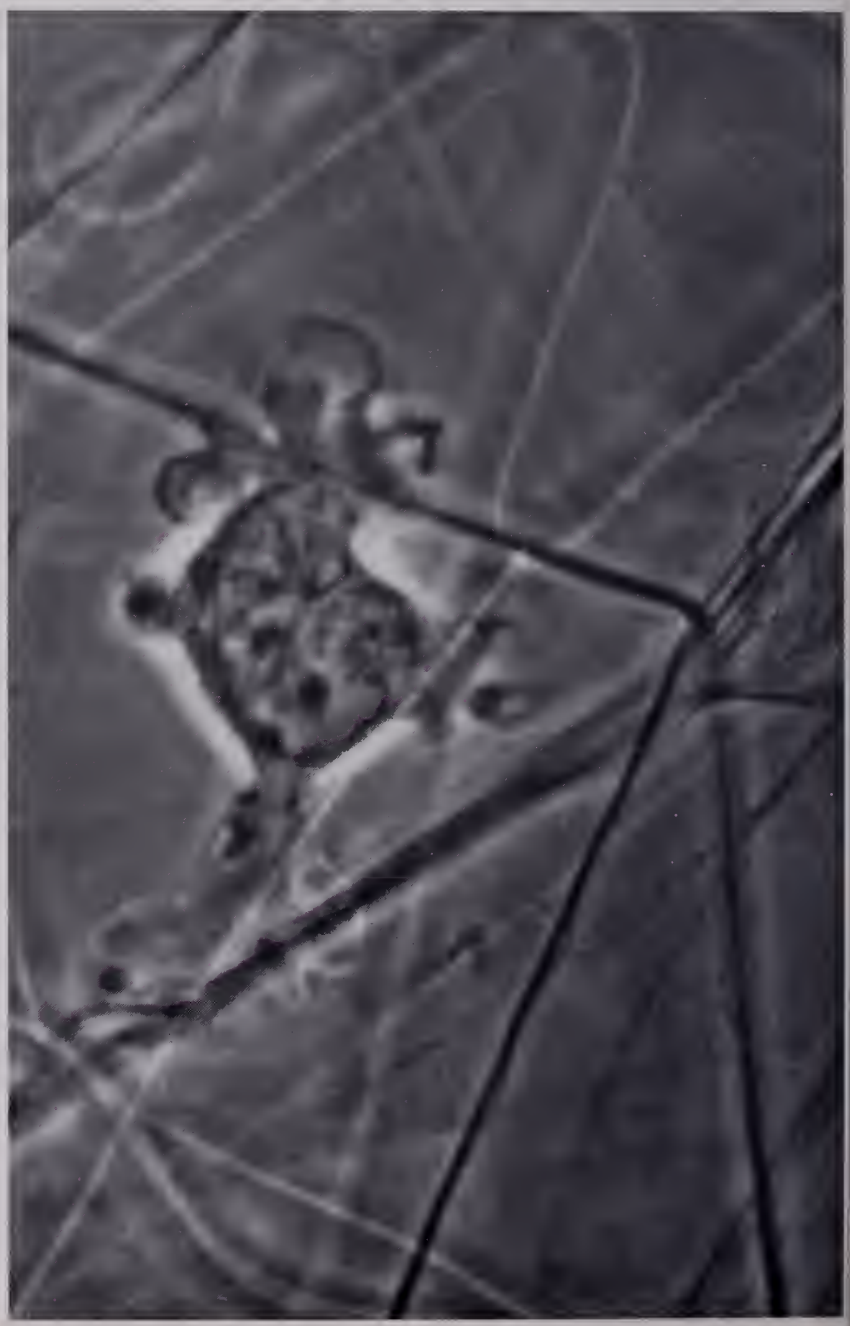
(Continued on Page 305)

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell – one of the most common found in connective tissue – has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die – one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another – factors that can be correlated with other chemical, biologic, and clinical parameters.

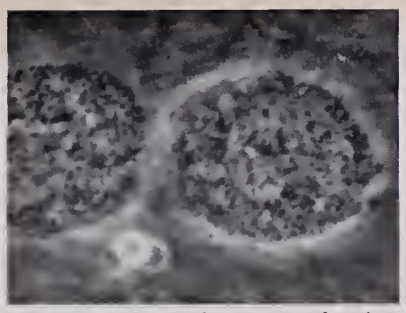


Visual evidence of how corticosteroids influence the inflammatory reaction

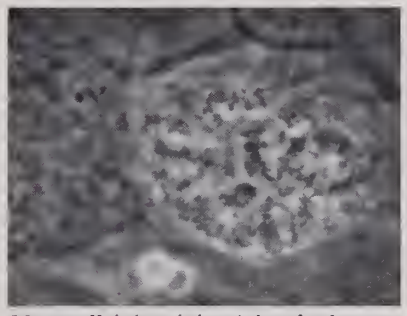
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



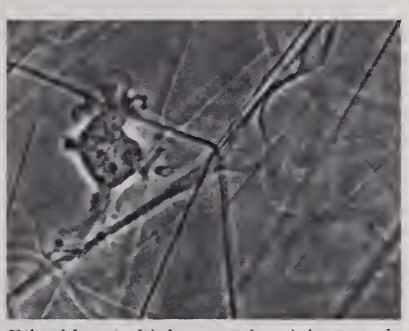
Phase-contrast microscopy showing mast cell before injury.



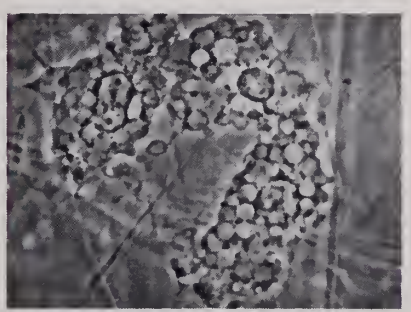
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid — Synalar (fluocinolone acetonide) — the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



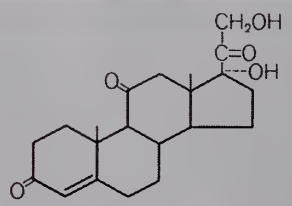
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

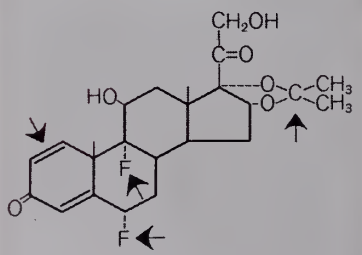
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

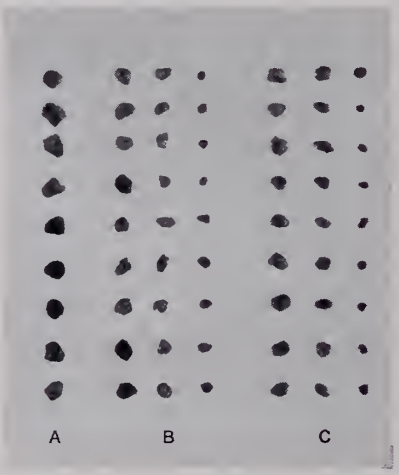


Fluocinolone Acetonide (Synalar)

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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For inflammatory dermatoses... by any measure a topical corticosteroid of choice

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Milligram for milligram one of the most active topical corticosteroids available

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Results often comparable to those of systemic corticosteroids with fewer hazards

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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ERC Conference — June 10

The Kentucky Medical Association has been invited to co-sponsor a Conference on Emergency Room Care in Kentucky at the Stouffer's Inn in Louisville on Saturday, June 10. Scheduled to be co-sponsors with KMA are the Kentucky Hospital Association and the Trauma Committee of the Kentucky Chapter, American College of Surgeons.

KMA Disaster Medical Care Committee Chairman, William T. Rumage, Jr., M.D., Louisville, has extended an open invitation to all Kentucky physicians who would like to attend the conference and discuss the problems of emergency room care. More detailed information will be provided in a later issue of the Journal.

McCracken Co. Soc., Host For 1st Trustee Dist. Meeting

First District physicians and their wives heard addresses by the three officials of the KMA and its Women's Auxillary at the Paducah Country Club, Paducah, under the chairmanship of Joseph Miller, M.D., Benton, KMA Trustee, with the McCracken County Medical Society as host.

Robert E. Pennington, M.D., London, KMA president, discussed the operations of the KMA, the duties of physicians in their communities, and benefits derived from their membership in professional and civic organizations.

Robert C. Long, M.D., Louisville, AMA representative for Kentucky, spoke on KEMPAC and AMPAC. He recommended that doctors and their wives actively support these organizations and should engage in more political activity. Also present at the meeting was Joseph Sanford, Executive Secretary of KMA.

Mrs. Raymond E. Jones, Louisville, president of the KMA Women's Auxillary addressed the wives of the physicians. Mrs. Jones was accompanied by Mrs. Charles Kissinger, president-elect of the Auxillary.

"Duke of Paducah" awards were presented to Doctor Pennington, Doctor Long, Mrs. Jones and Mr. Sanford.

Ob Section Elects Officers

Douglas M. Haynes, M.D., Louisville, was elected Chairman of the Section on Obstetrics of the Southern Medical Association, it was recently announced in Birmingham, Alabama. He will be responsible for arranging the program for the Section on Obstetrics for the 61st Annual Meeting of the Association, which will be held in Miami Beach, Fla., November 13-16.

Radiology Lectures Set for April

Kentucky Radiologists are invited April 15 and 16 to hear Richard H. Marshak, M.D., New York City, who will deliver the nineteenth annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati College of Medicine. Contact Benjamin Felson, M.D., Department of Radiology, Cincinnati General Hospital, for further details.

Anesthesiology Conf. Scheduled

The Fourth Anesthesiology Conference, sponsored by the Illinois Society of Anesthesiologists, will be held at the Palmer House in Chicago, May 11, 12 and 13. The theme of the scientific program will be "Physiologic Measurements in Clinical Anesthesia". For more information, contact Anna E. Barnstable, M.D., Publicity Chairman, 301 Oak Tree Lane, Waukegan, Illinois 60089.

KMA Council and Committee Reports

Cancer Coordinating Committee

Condict Moore, M.D., Louisville, Chairman

KMA Headquarters Office **January 4, 1967**

Review and discussion of the Cervical Cancer Screening Program sponsored by the American Cancer Cociety, State Department of Health, and endorsed by the Kentucky Medical Association, was the primary concern of this committee at its first meeting of the year. All members and invited guests concluded that the program would progress best if it were concentrated for the present in a few counties whose medical societies signified in writing a desire for a real screening program.

Education through the use of speakers, films, film strips, and literature available from the American Cancer Society was stressed as a most important element of promotion. In addition, the committee recommended that successful promotions utilized elsewhere be used as a guide for use in areas where promotional methods had not been as successful.

Perinatal Mortality and Morbidity Study Committee

Guy G. Cunningham, M.D., Ashland, Chairman, Presiding

KMA Headquarters Office **January 19, 1967**

The committee members reviewed current procedures of handling the high risk infant at birth and discussed methods of reducing infant mortality rates. A homogeneous form to be utilized in the follow-up procedure on premature and high risk infants is under study and development for hospital use when public health nurses make follow-up visits at the home.

In reducing infant mortality, the committee stressed the importance of using the team approach including the pediatrician, obstetrician, and public health nurses. For high risk and premature infants, visiting public health nurses may be especially helpful where the attending physician feels there is a need for such service. The establishment and use of nursery operating standards in Kentucky hospitals was also a part of the committe's consideration.

Dental-Nurse-Pharmacy and Related Groups Committee

A. Evan Overstreet, M.D., Louisville, Chairman, Presiding

KMA Headquarters Office **February 8, 1967**

At their recent meeting, members of the committee discussed the relationship of medicine with allied and related groups and how to effect better liaison.

Specific recommendations were made to the Board of Trustees concerning a joint policy statement with the Kentucky Pharmaceutical Association relating to prescription pads and a need to study the changing concept in nurse education, especially as it related to the supply of nurses. The next meeting of the committee was scheduled for May 11, 1967.

Council on Medical Services

George W. Pedigo, M.D., Chairman, Presiding

KMA Headquarters Office **February 9, 1967**

Holding its second meeting for this associational year, this council met to review the mid-year status of council and committee activities. A report on the AMA Socio-Economic Conference was heard from Walter L. O'Nan, M.D., Henderson, a member of the council; and, at the request of the council, a report by KMA Headquarters Office staff was received on the current activities of the KMA Physician Placement Service.

The council members discussed the activities and purpose of the council and forwarded a recommendation in this regard to the Commission to Study the Reorganization of KMA. After hearing and acting upon committee recommendations for transmittal to the Board of Trustees, the council scheduled its final meeting of this associational year for June 15, 1967.

Council on Legislative Activities

John C. Quertermous, M.D., Murray Chairman, National Affairs

Fred C. Rainey, M.D., Elizabethtown, Chairman, State Affairs

KMA Headquarters Office **November 16, 1966**

The Council on Legislative Activities held its first meeting for the new associational year on Wednesday, November 16, at which time legislation at the last congress was reviewed and possible pending legislation before the 90th Congress was discussed.

Plans were made for future activities of the Council, with a number of recommendations being passed for consideration by the KMA Board of Trustees.

Scientific Program Committee

Roderick Macdonald, Jr., M. D., Louisville, Chairman

KMA Headquarters Office **November 10, 1966**

The KMA Scientific Program Committee met recently to plan the scientific sessions for the 1967 KMA Annual Meeting, September 26-28. General sessions were planned for Tuesday morning, all day Wednesday, and Thursday morning. Specialty groups were scheduled to have sessions on Tuesday and Thursday afternoons.

In formulating a diversified program, the committee planned to present a taped color TV session, a tele-lecture or transatlantic program to be sponsored by Smith, Kline, and French Laboratories and outstanding papers on subjects within specific themes established for the four one-half day sessions.

It was agreed that final arrangements for scientific sessions would be made on December 7 when the presidents of all specialty groups participating in the 1967 Annual Session would meet with the KMA President and Chairman of this committee.

School Health Committee

O. B. Murphy, M.D., Lexington, Chairman

KMA Headquarters Office **February 1, 1967**

The committee members discussed numerous approaches to improving the overall health of the school age child to include physical and health education, veneral disease control, and programs designed to reduce athletic injuries. Close association with the State Department of Education as well as educational leaders at the local level, Parent and Teachers Association and other groups was considered essential in meeting the committee's obligations.

An exhibit on physical fitness will be staffed by members of the committee at the Annual Meeting of KEA in April and a recommendation was submitted to the KMA Board of Trustees that school superintendents be informed of the name of the county health chairmen in his area as the local school health advisor.

Executive Committee
Rural Kentucky Medical Scholarship Fund

C. C. Howard, M.D., Glasgow, Chairman

KMA Headquarters Office **January 25, 1967**

The Executive Committee of the Rural Kentucky Medical Scholarship Fund met on January 25, 1967, to review the Fund's operation and to make plans for the annual meeting of the Board of Trustees to be held in May.

A committee of three was appointed to study the possibility and feasibility of an increase in the designated critical and semi-critical counties and the amounts of the loans to be available for these individual programs.

It was also to consider including grants to medical students who would agree to go into the Kentucky Public Health Service upon completion of their training.

General Practice, grossing $56,000 a year, available in Ohio. Included is modern, air-conditioned building, complete equipment, drugs, records. Excellent clientele in pleasant small community with hospital. Doctor leaving to take residency. Available July, 1967. Liberal Terms, $23,000. Write: Robert E. Goyne, M.D., Route 5, Upper Sandusky, Ohio. This practice can be taken for 1 to 2 years also as a Locum Tenens on a financially very rewarding basis.

COUNTY SOCIETY REPORTS

Allen

On Thursday P. M., February 2, 1967, the Allen County Medical Society held its organizational meeting with the following officials elected for 1967:

President—Earl P. Oliver, M.D.

Vice-President—John M. Hall, M.D.

Secretary and Treasurer—Owen L. Davis, M.D.

At the present time there are five active members of the Society.

The Allen County Medical Society again wishes to express its opposition to certain aspects of the Administration of Titles XVIII and XIX of the Social Security Act; especially as it applies to common recipients. Particularily the: present billing system, obtaining signatures, voluminous paper work, frequent directives, dual fee schedules and the prohibition of direct billing under Title XIX.

We are encouraged in our opposition to the present administration simultaneously of Titles XVIII and XIX by the voluminous favorable response from so many component Societies to our recent letter to all Societies.

NEWS ITEMS

Sohrab Amini, M.D., has opened his office in Henderson, limiting his practice to general surgery. Doctor Amini graduated from the Kansas University in 1950 and completed his internship at the Providence Hospital in 1951. After serving in the U.S. Army Medical Corps from 1955 to 1957, he completed his residency training at the University of Louisville in 1966.

W. F. Carter, M.D., Pleasureville, was recently commissioned a Kentucky Colonel by Governor Edward Breathitt, in recognition of his sixty years of medical service as a general practitioner. Doctor Carter graduated from the Hospital College of Medicine, Louisville, in 1907, practiced at Broadhead, Kentucky for fifteen years, and moved to Pleasureville in 1922.

The new gymnasium of the Cawood High School in Harlan County will be called the "S. H. Rowland Gymnasium", in honor of S. H. Rowland, M.D., Evarts. Doctor Rowland has been chairman of the Harlan County School Board for the past thirty-three years.

New Ambulance Equip. Available

It was reported by the KMA Perinatal Mortality and Morbidity Study Commitee that equipment is now available for ambulances transporting high-risk babies. Members of this committee feel that ambulances should include proper electrical power to supply heaters in baby isolettes.



when he just can't sleep

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Sodium Amobarbital and Sodium Secobarbital

(One-Half Sodium Amobarbital and One-Half Sodium Secobarbital



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal, comprised of equal parts of Seconal® Sodium (sodium secobarbital, Lilly) and Amytal® Sodium (sodium amobarbital, Lilly), is indicated for prompt and moderately long-acting hypnosis.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



Dosage: 1½ to 3 grains at bedtime.

Supplied: ¾, 1½, and 3-grain Pulvules®.

Additional information available to physicians upon request.

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Lilly

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Sc. Exhibitors Urged, Plan Now

T. R. Marshall, M.D., chairman of the KMA Scientific Exhibits Committee, urges all physicians interested in presenting scientific exhibits to make plans and application to do so at the 1967 KMA Annual Meeting. Exhibits need not be expensive or professionally constructed but should have a good subject and be of teaching value.

This year's Annual Meeting will be held at the Louisville Convention Center, September 26-28. A scientific exhibit application can be found on page 328 of this issue of the KMA Journal. For further information, please contact the KMA Headquarters Office.

How Physicians Work to Win

How physicians Work to Win in Politics will be the focus of a coming address at the 18th Annual KMA Interim Meeting, April 19 and 20 at Ken-Bar Inn, Gilbertsville.

William J. Lewis, M.D., Dayton, Ohio, will speak at the Thursday morning session on the subject "Working to Win." Doctor Lewis is a leader in OMPAC (Ohio Medical Political Action Committee), which enjoyed considerable success in the 1966 elections. The KEMPAC Board of Directors urges every physician attending the Interim Meeting to avail himself of the opportunity to hear Doctor Lewis.

KTRDA To Meet April 6

The Kentucky Tuberculosis and Respiratory Diseases Association will hold its 1967 Annual Meeting April 6 at the University of Kentucky Medical Center in Lexington.

42 year old G.P. (A.A.G.P.) desires male associate, age 25-45. Southern California opening July 1, 1967, to associate with G.P. established 14 years, as replacement for well established associate of 11 years leaving for residency. Excellent income with salary guarantee and/or percentage, as desired, and eventual partnership possible. O.B. optional; excellent modern hospital facilities with teaching centers nearby. Modern, well equipped, air conditioned office, with six aides, located in Whittier, Calif. midway between nearby beach, mountain, and desert resorts, all with outstanding recreational facilities. Nearby metropolitan area offers cultural and educational opportunities.

J. C. Picklesimer, M.D.
1505 East Oak Street
Whittier, California

In Memoriam

C. M. RICE, M.D.
Owensboro, Ky.
1876-1967

C. M. Rice, M.D., 91, Owensboro general practitioner, died January 22, at the Owensboro-Daviess County Hospital, following a short illness. Doctor Rice graduated from the University of Louisville School of Medicine in 1905, and was awarded degrees by the University of Kentucky and the Chicago Poly Clinic. He moved to Owensboro in 1924, having previously practiced in Chambers and Sutherland.

PUBLIC HEALTH PAGE

(Continued from Page 279)

evaluations of his patient to determine if they should continue to receive medication.

Any physician wishing more information about the program should write or call Donald Austin, M.D., Office of Chronic Disease, telephone number—564-4937, in the State Health Department at Frankfort or contact their county health department.

IN THE BOOKS

(Continued from Page 232)

grams with the corresponding line-drawn figures are quite descriptive.

The concise discussion of the mechanisms responsible for control of blood flow serves as a good introduction to the understanding of the manifestations of the arterial disease and its management.

The section on diagnostic problems and methods is brief but adequate.

Chapters on treatment and operative techniques represent mainly the author's own experience and that of his colleagues. He discusses various methods of reconstructive vascular procedures, including the use of synthetic prostheses and autogenous venous grafts. His enthusiasm about extensive endarterectomy, lumbar sympathectomy, effectiveness of vasodilator drugs and about post-operative heparinization, however, may not be shared by the majority of vascular surgeons.

The readers are timely warned about the major complications of vascular operations. The suggestions made for their prevention are plausible.

This little book should prove a useful addition to the reading list of the students of vascular surgery.

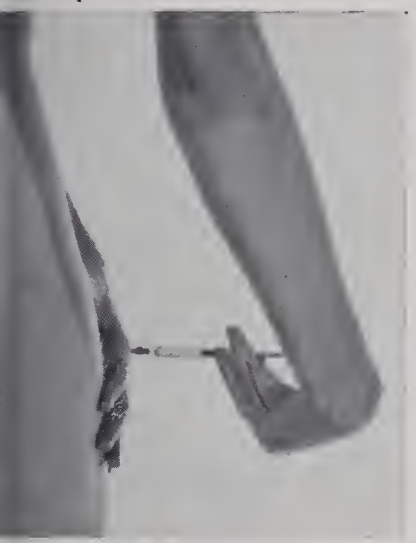
M. Atik, M.D.

New
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for broad-spectrum activity
plus specific antifungal prophylaxis
at significant patient savings

Whenever tetracycline is indicated in these candidates for Candida:

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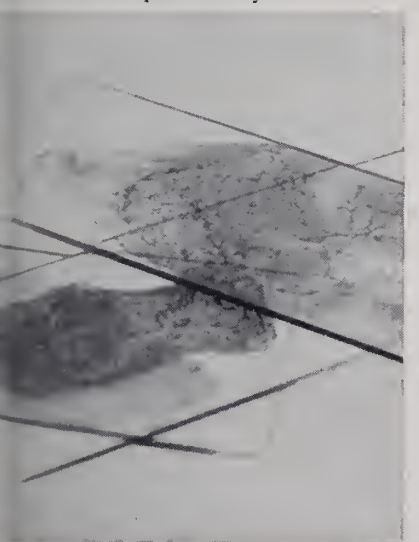
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



atients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indicotions:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Controindicotions:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood.) *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reoctions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosoge:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Division of Bristol-Myers Company
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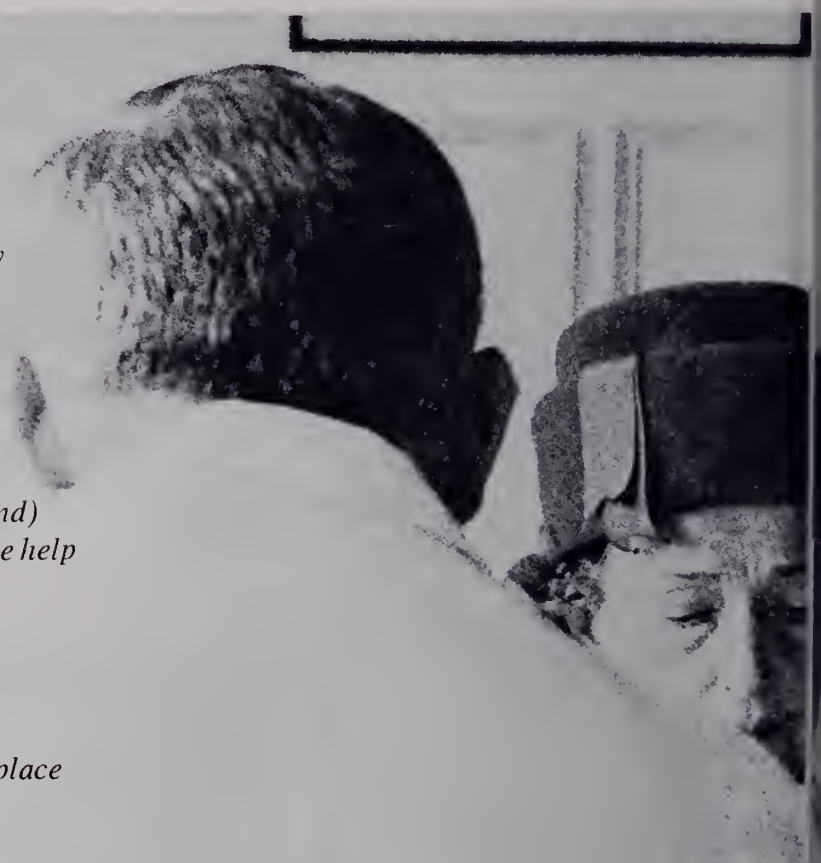
Tetrex-F®

ach capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

Tetrex-F is priced lower
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There is a growing senescent body of people on their way to malignant inactivity, who sorely need your interest and direction to help them back to a more active and useful life. There are medicines too, designed to help. One such has proved useful in clinical practice.



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

Mediatric®

Designed for the "metabolically spent"

Nutritional reinforcement for those who can't – or won't – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation.* It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

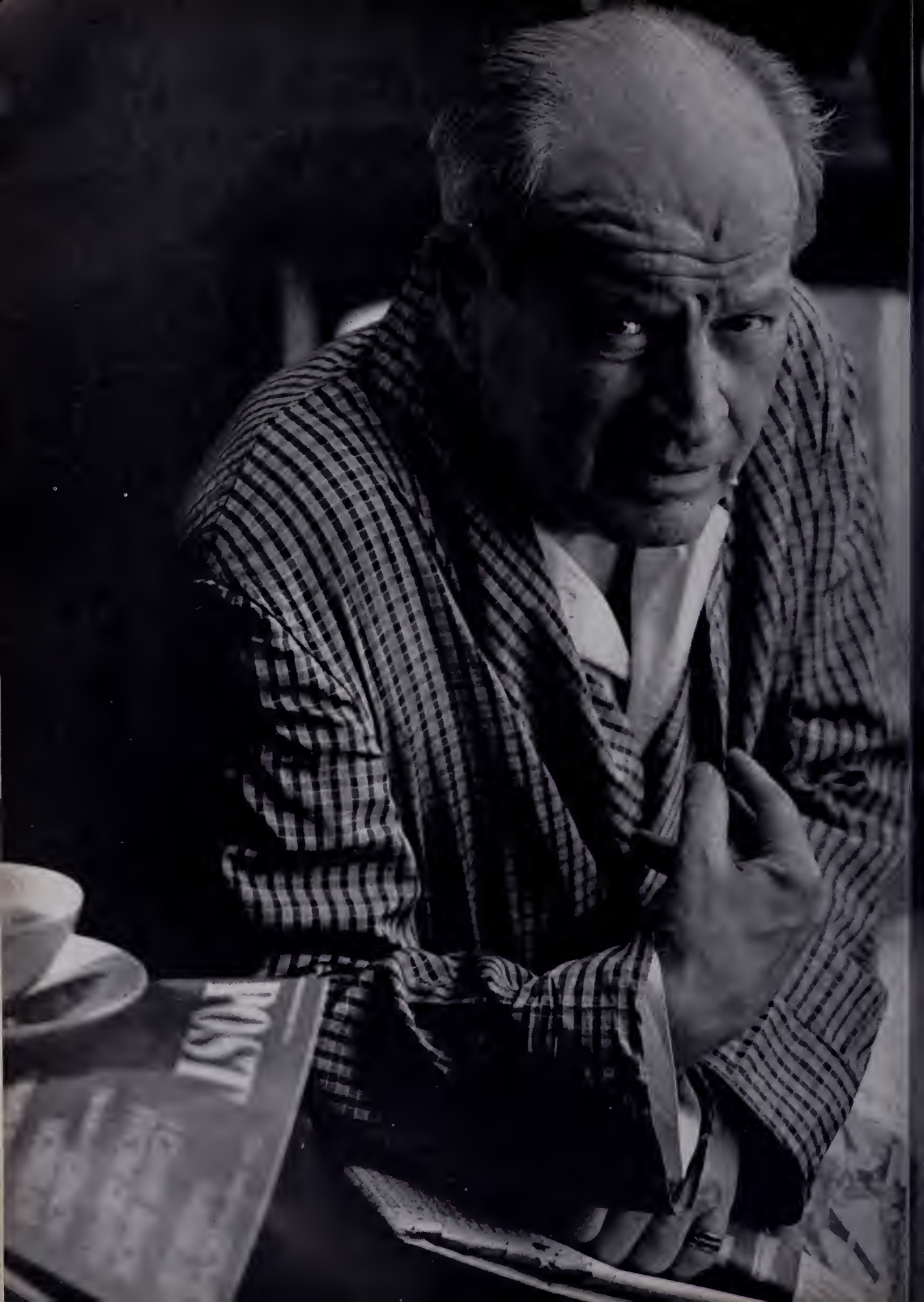


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I'm supposed to get up and do things?

With my heart?

It's entirely natural—and may even be desirable—for the cardiovascular patient to be somewhat anxious about himself.

But when anxiety leads to unreasonable self-imposed limitations and restrictions . . . when it aggravates cardiovascular symptoms . . . when it interferes with restful sleep, measures to help alleviate the anxiety are probably in order.

One measure, of course, is reassurance. Another, adjunctive measure, is EQUANIL (meprobamate).

Over a decade of experience has shown that EQUANIL (meprobamate) is generally well tolerated as well as effective. Side effects are usually limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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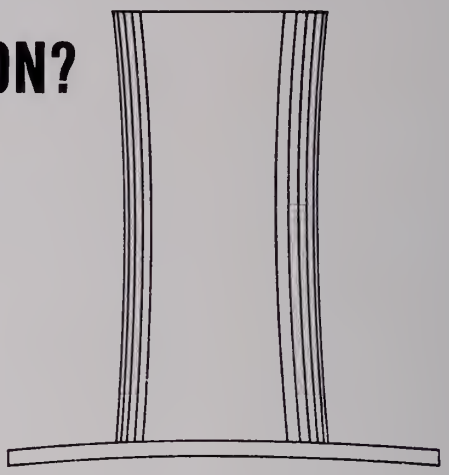
to help relieve anxiety and tension occurring alone or secondary to organic disease

Equanil® (meprobamate)

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OPTICAL ILLUSION?

Height and width of this hat are equal, but the unbroken height of the crown appears greater than the interrupted width of the brim. Don't play games with your eyes. Some glasses are poorly crafted. Rely on Southern Optical accuracy.



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Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

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Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

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Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

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What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

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WILLIAM H. RORER, INC.
Fort Washington, Pa.

Doctors

You are invited to attend

KENTUCKY THORACIC SOCIETY SCIENTIFIC SESSION

on

PULMONARY DISEASE

April 6, 1967

Medical Center — University of Kentucky

PROGRAM

8- 9 o.m. — Room NM 463

Pediatric Grond Rounds: Cose presentotion ond discussion of pulmonory problems in children

9 - 12 noon — University Hospitol Auditorium

"An Approach ot Dyspneo"

Introductory Remorks—E. D. Pellegrino, M.D., Deon ond Choirmon, Deportment of Medicine, New York Stote College of Medicine

Clinicol presentotions illustroting:
Airwoy Diseose
Interst:tial Disease
Discussion by Dr. Pellegrino
Commentary by Drs. J. E. Cohn, Lester Bryont, Peter Bosomworth

12 noon — Luncheon — Imperial House

"The Chonging Yeors" Dr. Pellegrino

2— 4:30 p.m. — University Hospital Auditorium

"Case Presentations"—A series of interesting ond problem coses of pulmonory disease by KTS members

KENTUCKY THORACIC SOCIETY 1954

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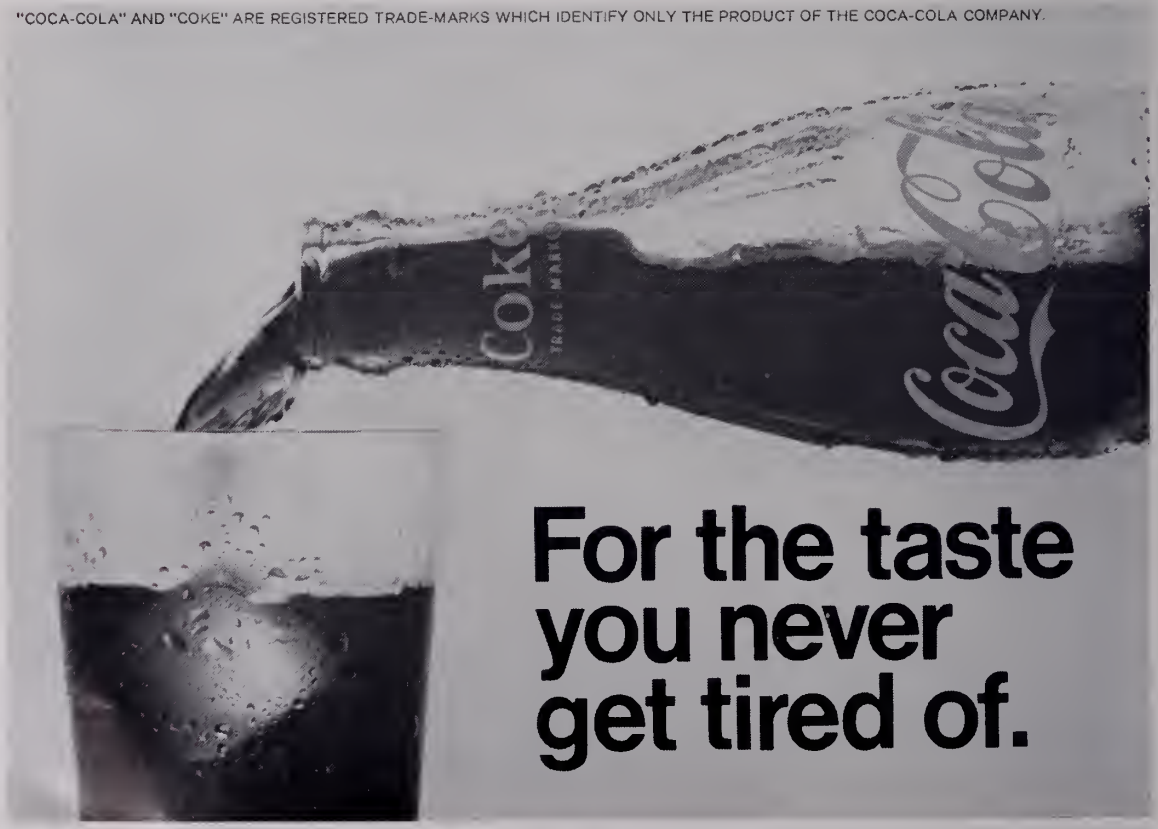
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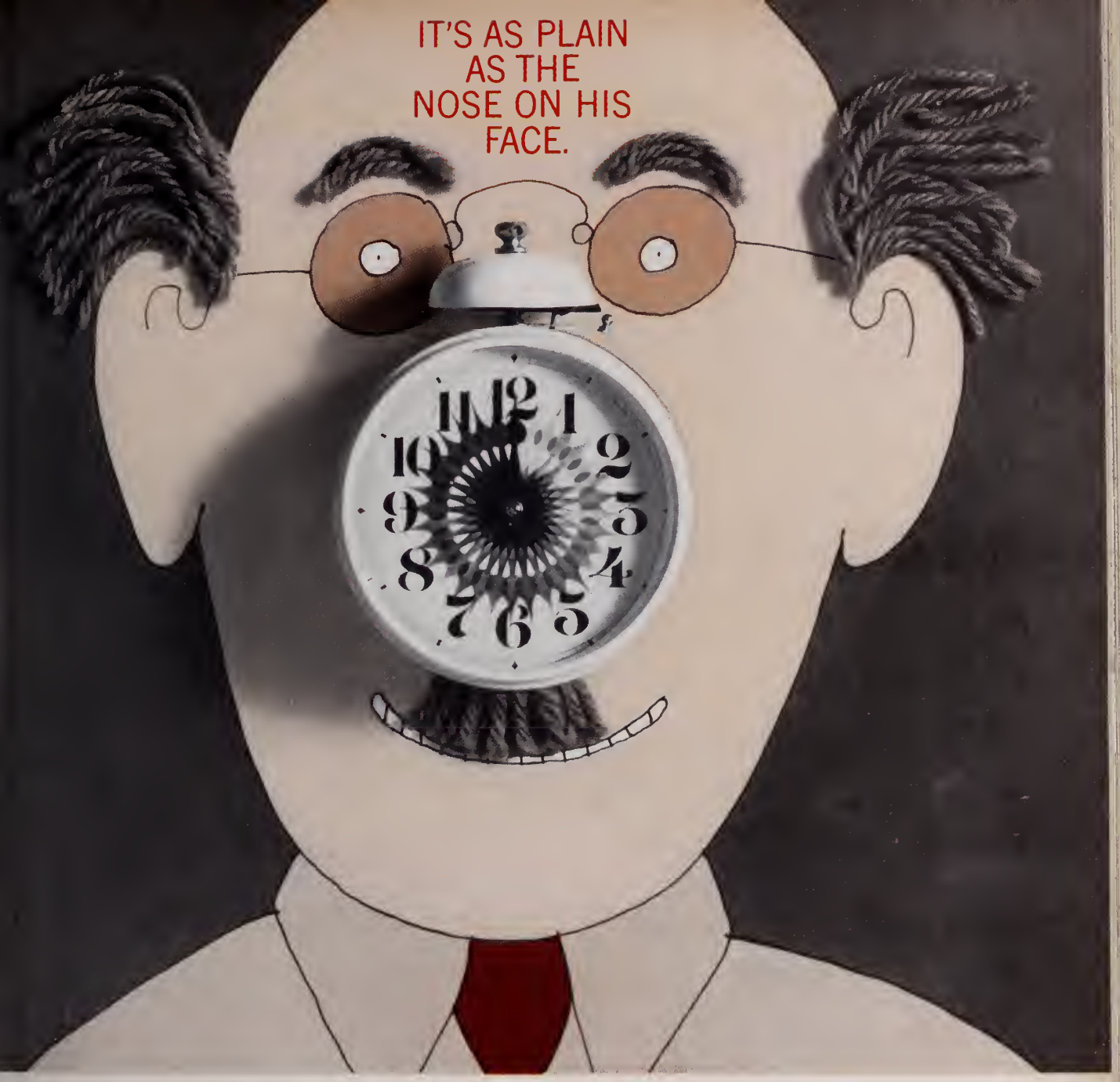
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Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

sinusitis, colds, or U.R.I.,
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eathe easy again. Each Extentab
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tamine reported in one study to have
cited side effects as few as the placebo,*
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a dependable 10- to 12-hour form.

iller, I. W., and Lowell, F. C.: New England
ed. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

Dosage: 1 Extentab morning and evening, or as needed.

Supplied: Bottles of 100 and 500.

Also available: Dimetapp® Elixir for conventional *t.i.d.* or *q.i.d.* dosage. See package insert for further details.

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Generic prescribing allows a third party to choose for you. This does not of necessity ensure therapeutic effectiveness or lowest patient cost.

You can prescribe the quality and purity of ACHROMYCIN® V Tetracycline-Lederle at a cost that is within pennies-a-day of the low-priced generic tetracycline.

When you prescribe tetracycline, write ACHROMYCIN V. It's good policy, good medicine and good economy, all in one prescription. LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York.

MAJOR PRICE REDUCTION JAN. 15, 1967

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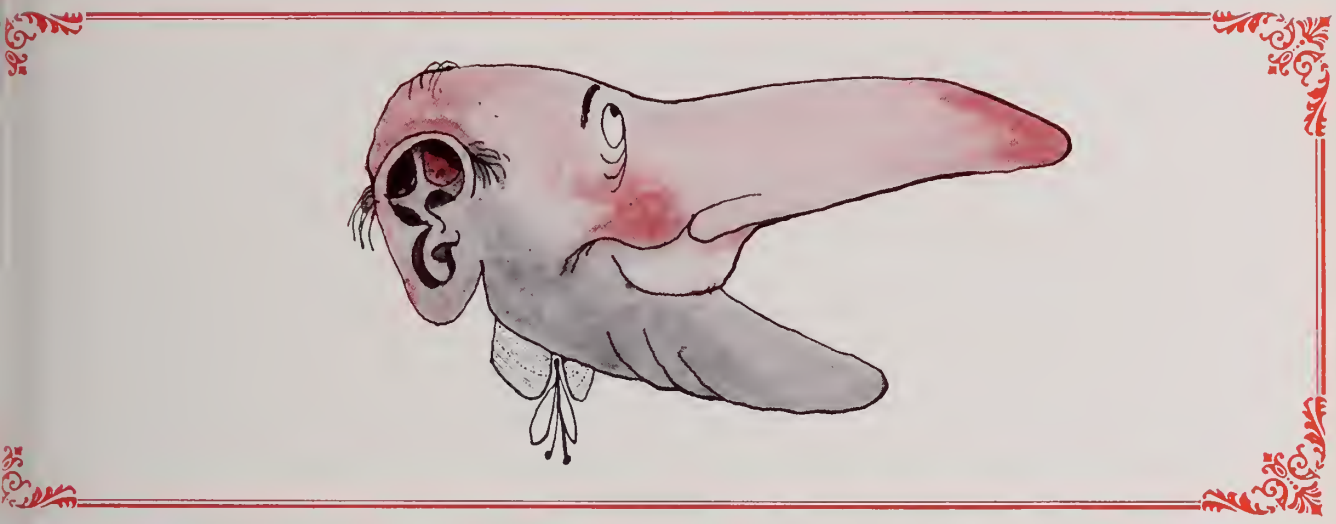
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The Proof of Excellence is in the Performance

for noses of every description, one safe and sure prescription:

Otrivin®

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on Rx only







■ quickly relieves congested nose
■ action is gentle, yet prolonged
■ side effects are minimal

DICATION: Nasal congestion. CONTRAINDICATION: Do not use patients sensitive to small doses of sympathomimetic substances. ARNINGS: Prolonged or excessive use may cause rebound congesn. Use cautiously in patients with hyperthyroidism, coronary artery ease, hypertension, and diabetes. CAUTION: Do not shake Nasal ray. Rinse Nasal Solution dropper or Nasal Spray tip in hot water er each use. No more than one person should use the same dropper ttle or nasal spray.
DE EFFECTS: Occasional local reactions: rebound congestion, ght burning or stinging, sneezing, dry nose. Occasional systemic ects: headache, drowsiness, lightheadedness, insomnia, palpitans. Overdosage in young children may produce profound sedation. OSAGE: **Adults:** *Nasal Solution*—2 or 3 drops in each nostril every o 6 hours. *Nasal Spray*—Squeeze rapidly once or twice in each nosl every 4 to 6 hours. **Children under 12:** *Pediatric Nasal Solution*—or 3 drops in each nostril every 4 to 6 hours. One drop should be used in infants under 6 months. *Pediatric Nasal Spray*—Squeeze rapidly once in each nostril holding tube upright; repeat every 4 hours as necessary. SUPPLIED: OTRIVIN® hydrochloride (xylometazoline hydrochloride CIBA) *Nasal Solution*, 0.1%; dropper bottles of 1 fluidounce, bottles of 1 pint. *Nasal Spray*, 0.1%; plastic squeeze tubes of 15 ml. *Pediatric Nasal Solution*, 0.05%; dropper bottles of 1 fluidounce. *Pediatric Nasal Spray*, 0.05%; plastic squeeze tubes of 15 ml. *Nasal Solutions* contain either 0.1% or 0.05% xylometazoline hydrochloride, triethanolamine, hydrochloric acid, sodium chloride, and phenylmercuric acetate 1:50,000 as preservative in water. *Nasal Sprays* contain either 0.1% or 0.05% xylometazoline hydrochloride, potassium phosphate monobasic, potassium chloride, sodium phosphate dibasic, sodium chloride, and benzalkonium chloride 1:5000 as preservative in water. *Consult complete literature before prescribing.*
CIBA Pharmaceutical Company, Summit, N. J.

CIBA

2/3329 MKL-1


Do your patients
shell out too much
for a diuretic?

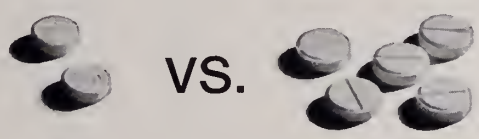
The answer may be yes... if they're not on Hygroton. For instance, a therapeutic dose of a short-acting diuretic may cost 3 times as much as an equivalent dose of Hygroton. With Hygroton, in fact, you can usually do the job with just one tablet a day or one every other day. It's no wonder that the trend has been away from short-acting, multiple-dose, high-cost diuretics.

You may hear that a short-acting diuretic was more effective in a 400 mg. (ten-tablet) dose than Hygroton in a 200 mg. (two-tablet) dose.

If one considers maximum recommended doses for each product, tablet for tablet Hygroton was clearly superior. Two tablets of Hygroton were found to produce almost 40% more natruresis and 20% more weight loss than five tablets of the other diuretic.* Note that these are maximum recommended doses!

For effectiveness, economy, and convenience, therefore, Hygroton is the diuretic to choose to start with and the one to stay with.

*Brest, A. N., et al.: J. New Drugs 5:329, 1965.



Natruresis above control values after maximum recommended doses (mEq./24 hours) in "normal" patients

111	152
5 tablets short-acting nonthiazide diuretic	2 tablets Hygroton

48-hour weight loss after maximum recommended doses in edematous patients with congestive heart failure due to arteriosclerotic or rheumatic heart disease

1.84 lbs.	2.2 lbs.
5 tablets short-acting nonthiazide diuretic	2 tablets Hygroton

Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Dizziness, weakness, nausea, vomiting, hyperglycemia, hyperuricemia, headache, muscle cramps, postural hypotension, constipation, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin reactions, including urticaria and purpura, epigastric pain, or G.I. symptoms after prolonged administration.
Average Dosage: One tablet (100 mg.) with breakfast daily or every other day.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.
6524-V(B)

HY-4736S

Hygroton®
chlorthalidone

Geigy
Geigy Pharmaceuticals
Division of
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THE INSURANCE PAGE



Rising Cost of Health Care

THERE is little question that one of the key issues we will face in the months ahead is the rising cost of health care. Many physicians are concerned about wide publicity being given statements from various public officials warning against possible inflation of doctor's fees when Medicare gets going. Even before the Medicare program had been in operation for two months, President Johnson ordered a quick Federal investigation into climbing medical care costs. And, almost concurrently, a newspaper article emanating from New York carried a misleading headline that physicians had increased their charges 300 percent since the advent of Medicare. It would be foolhardy to think that these moves to find a scapegoat for the rise in medical care costs will not continue.

Certainly we can point out that sophisticated medical economists had cautioned earlier that certain built in features of the Medicare law would result in increased health care costs. But that will have little impact on the public which has to pay for health care directly or through increased taxes.

Nearly every organization in the health care field has conducted studies and are continuing their inquiries into the cost of medical care. The health care team has a positive story to tell. Tremendous scientific advances in the past 20 years have necessitated the development of more complex and precise instruments and more intensively trained medical and paramedical personnel. Increased health education of the public at all levels has been a major factor in creating a much greater demand for traditional and new medical services that was not anticipated.

The patient is paying more—but he is receiving more—and a higher quality product.

The health care team has also carried out programs to conserve health care dollars through utilization review activities and public education programs urging patients to make wise use of services available.

For the year ahead, we must continue to inform the public on the cost of medical care and the true reasons for its increase. We must also be prepared to answer incorrect allegations wherever they occur.

WILLIAM W. HALL, M.D.

Look how many ways

Thorazine®

brand of

chlorpromazine

can help

	Tranquilizer	Potentiator	Antiemetic
Agitation	●		
Alcoholism	●		●
Anxiety	●		
Cancer patients	●	●	●
Severe neurodermatitis	●		
Drug addiction withdrawal symptoms	●		●
Emotional disturbances (moderate to severe)	●		
Nausea & vomiting	●		●
Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
Psychiatric disorders	●		
Hiccups—refractory	●		
Senile agitation	●		
Surgery	●	●	●
Tetanus	●	●	

'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. *Contraindications:* Comatose states or the presence of large amounts of C.N.S. depressants. *Precautions:* Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. *Side Effects:* Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories SK&F





TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Weighing on his mind, too

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, nonnarcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1967 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 26, 27, 28**

Fill Out and Mail to:

THOMAS R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

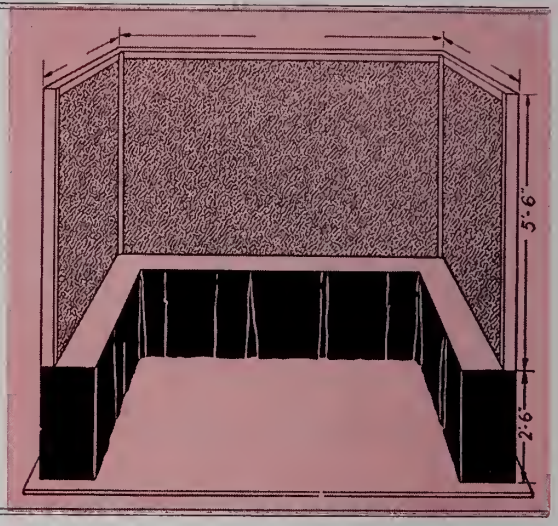
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1967

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....
   Institution (if desired): .....
   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays....
   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
   Amount of total wall space needed? .....
   Back wall .....Side walls (All side walls are 4') .....
   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Mead Johnson Aesculapius Award of $200.00 and identifying plaque will be presented by the KMA for the best exhibit in 1967.

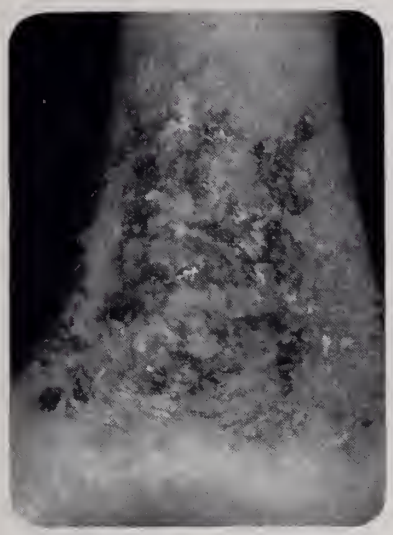
The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

Eczema of many years... controlled in two weeks



Before treatment



After treatment — with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

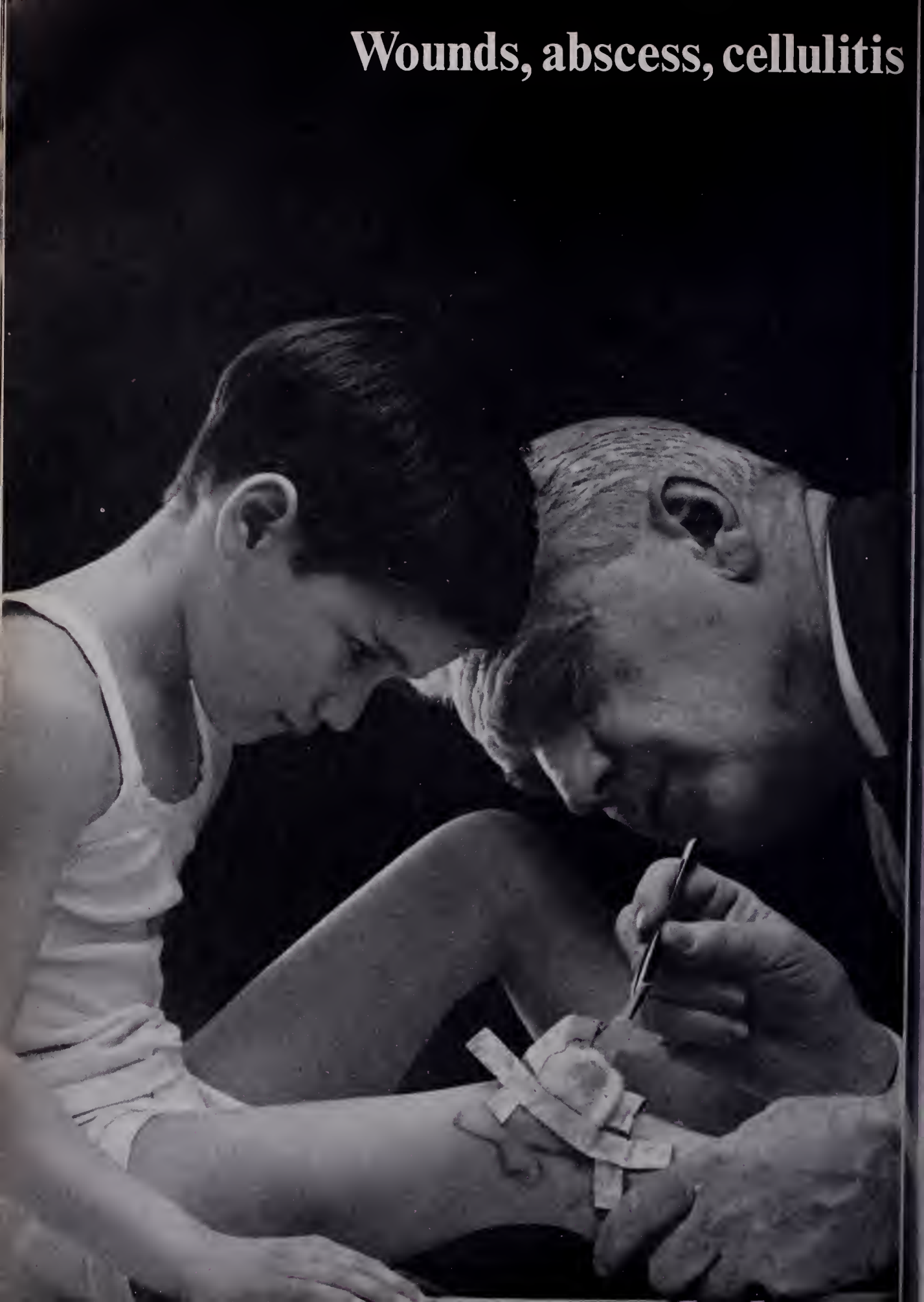
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Triamcinolone Acetonide
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Wounds, abscess, cellulitis



...and the complications of staph.

Staph reliably controlled with specific therapy



A suitable dosage form for every staph situation

From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

Bactericidal

Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Whenever you suspect staph PROSTAPHLIN®

SODIUM OXACILLIN

How long will it take him to recover from the flu if he just doesn't care?



Does he really care? Is he alert, encouraged, positive and optimistic about getting out of bed and back to work soon?

Or is he giving in to the depressing impact of confinement?

When functional fatigue complicates convalescence, Alertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that so often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Alertonic®

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
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Night Leg Cramps...Frequent Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]



now...specific therapy for night leg cramps

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

QUINAMM Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 4 grains (250 mg.) and Aminophylline 3 grains (200 mg.). **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptams af cinchanism, such as tinnitus, dizziness, and gastraintestinal disturbonce. Discontinue use if ringing in the ears, deafness, skin rash, or visuol disturbances occur. **Contraindication:** QUINAMM is contraindicoted in pregnancy because af its quinine content. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to ane tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles af 100 and 500 tablets. **Caution:** Federal law prahibits dispensing without prescription.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

WALKER *Laboratories* Division of Richardson-Merrell Inc., Mount Vernon, New York 10551

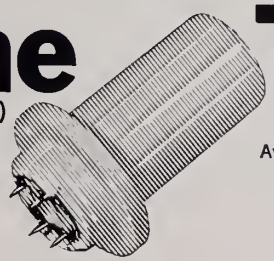
what time is it?

For the past
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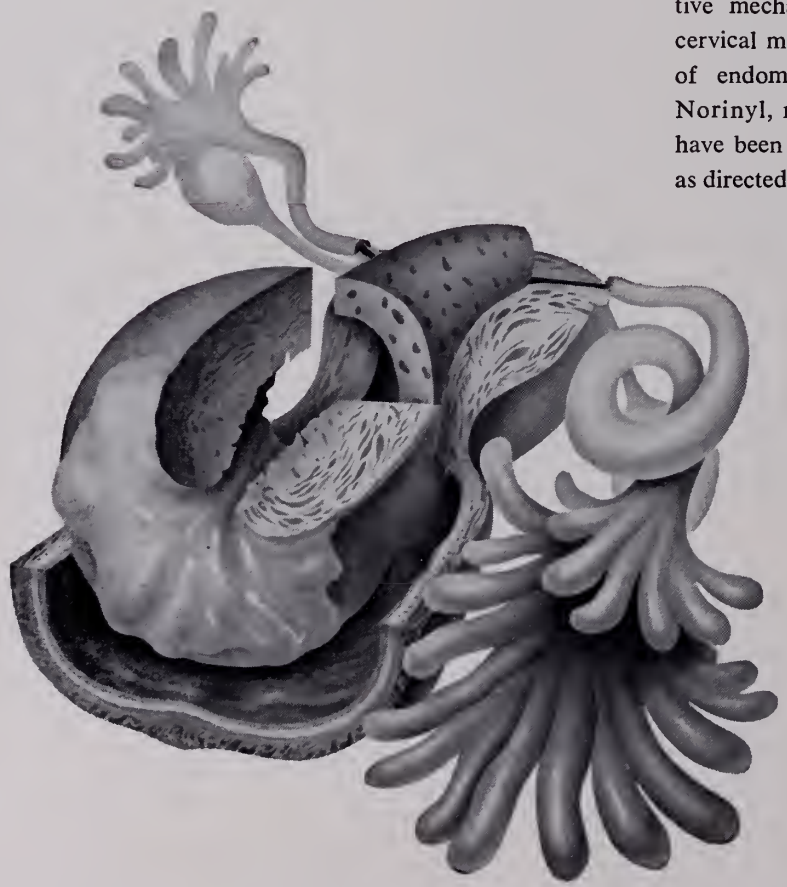
Norinyl® tablets
(norethindrone 2 mg. c mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects
Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage
An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.
Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.
Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.
Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.
NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.
Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)
Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
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LABORATORIES INC., PALO ALTO, CALIF.

Norinyl tablets
(norethindrone 2 mg. c mestranol 0.1 mg.)
for multiple contraceptive action

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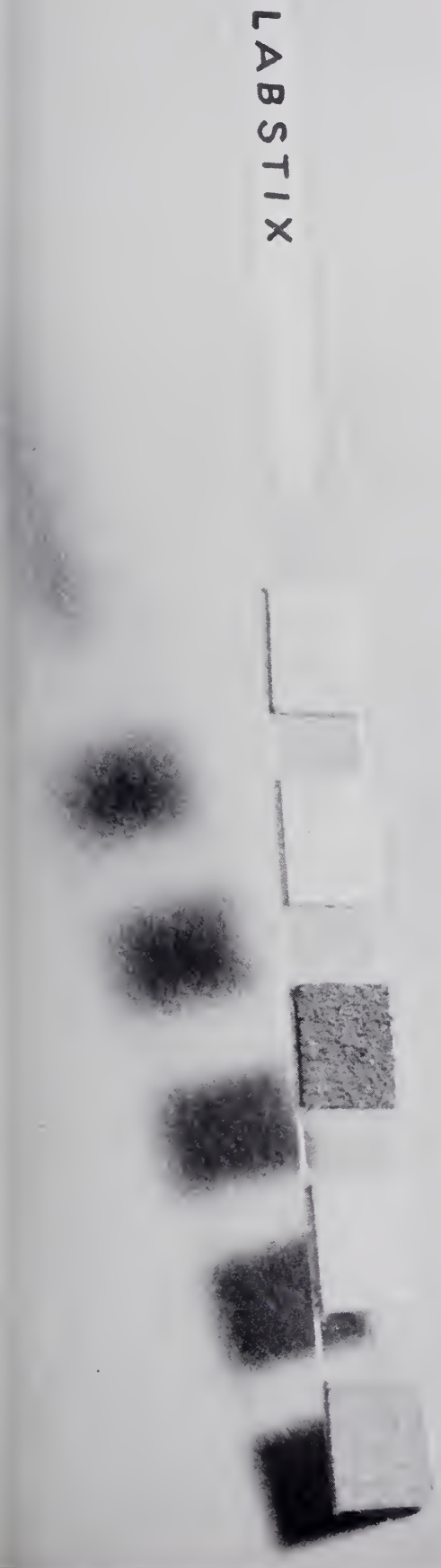
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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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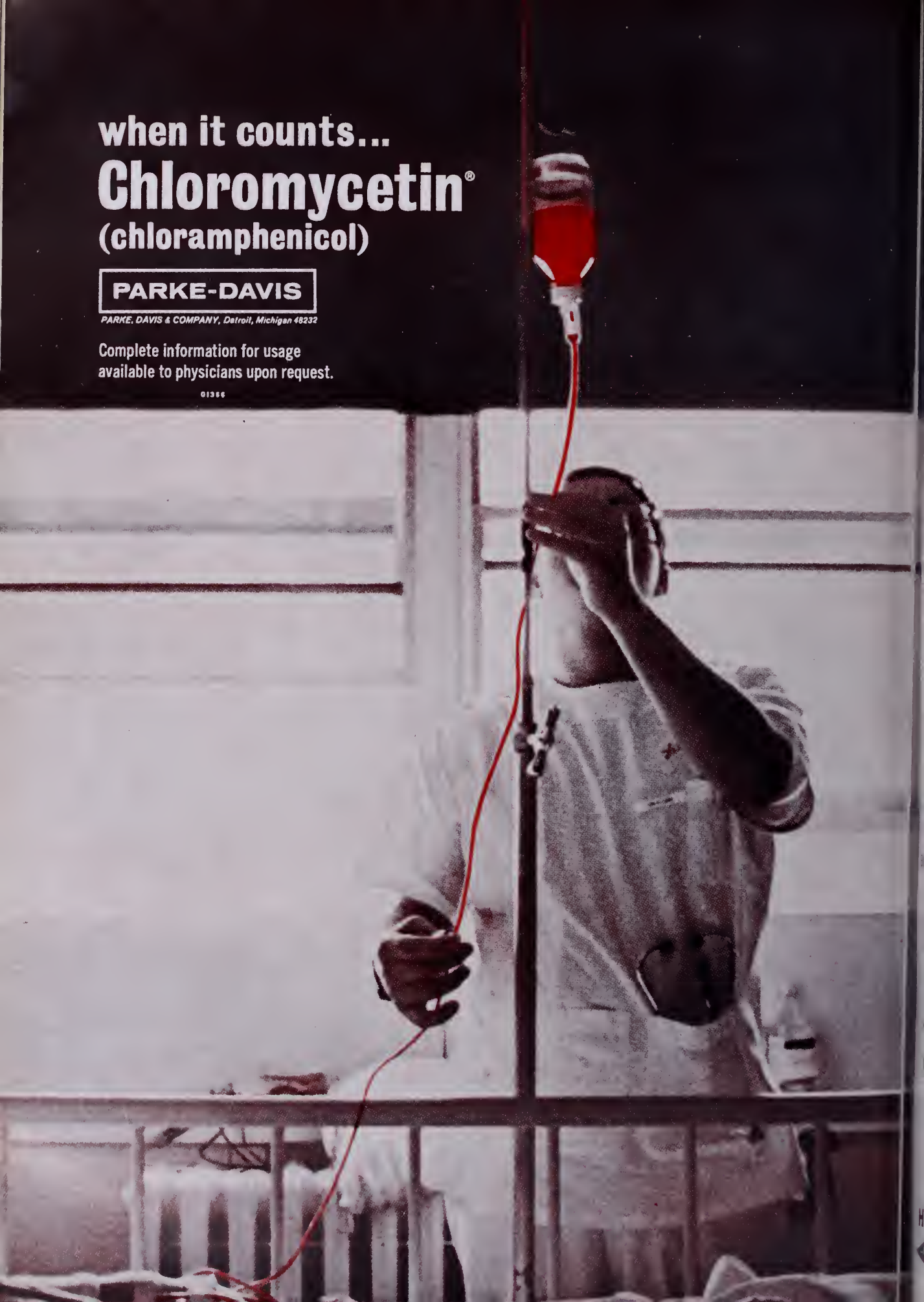
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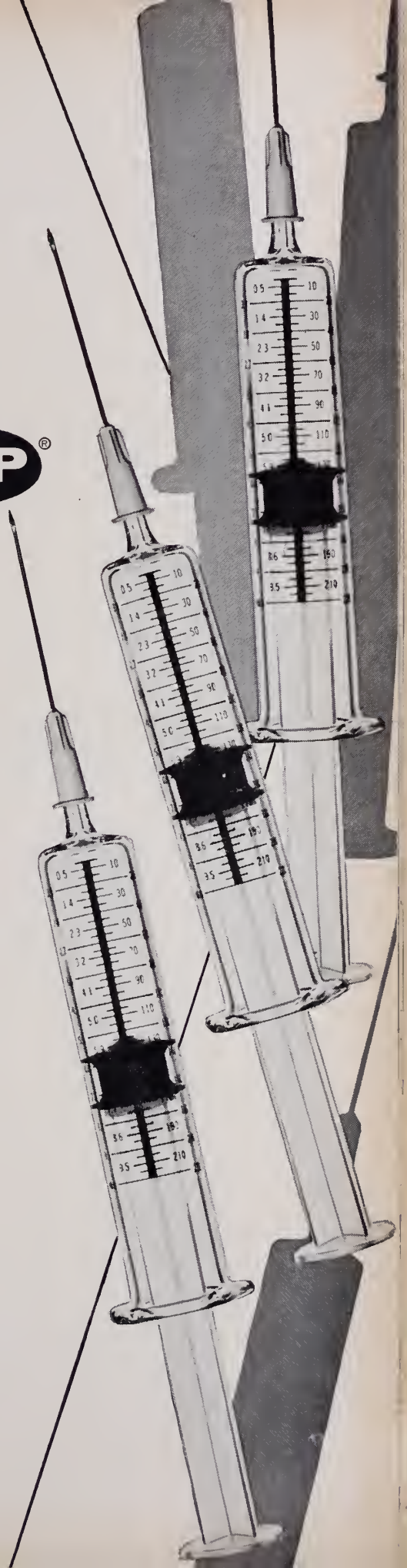

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Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

cations: Urinary tract infections caused by gram-negative and some gram-ive organisms.

effects: Mainly mild, transient gastrointestinal disturbances; in sional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild nophilia, reversible subjective visual disturbances (overbrightness of s, change in visual color perception, difficulty in focusing, decrease in l acuity and double vision), and reversible photosensitivity reactions. ed overdosage, coupled with certain predisposing factors, has produced convulsions in a few patients.

autions: As with all new drugs, blood and liver function tests are advis- during prolonged treatment. **Pending further experience, like most notherapeutic agents, this drug should not be given in the first trimester egnancy. It must be used cautiously in patients with liver disease or re impairment of kidney function.** Because photosensitivity reactions have rred in a small number of cases, patients should be cautioned to avoid cessary exposure to direct sunlight while receiving NegGram, and if a ion occurs, therapy should be discontinued. The dosage recommended dults and children should not arbitrarily be doubled unless under the ul supervision of a physician. Bacterial resistance may develop.

n testing the urine for glucose in patients receiving NegGram, Clinistix® ent Strips or Tes-Tape® should be used since other reagents give a -positive reaction.

ge: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times) for one to two weeks. Thereafter, if prolonged treatment is indicated, fosage may be reduced to two Gm. daily. Children may be given oximately *25 mg. per pound* of body weight per day, administered in ed doses. The dosage recommended above for adults and children ld not arbitrarily be doubled unless under the careful supervision of a ician. Until further experience is gained, infants under 1 month ld not be treated with the drug.

supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conve- tly available in bottles of 56 (sufficient for one full week of therapy) and in es of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

rences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on est. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: nicrobial Agents and Chemotherapy—1964, Ann Arbor, American ety for Microbiology, 1965, p. 722.

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eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

MESSAGE FROM THE PRESIDENT



ORGANIZED medicine in recent years has had more than its share of criticism. Why? And was this criticism justified? I think organized medicine, like any other large organization that takes firm policy stands for or against issues, inevitably builds for itself a group of detractors—both in and out of the profession.

I think there is a parallel here between medicine and the government and peoples of the United States. The American nation has been the most generous in all history in giving of its resources and the sacrificing of American lives for the relief of hunger, suffering, and the preservation of freedom. Yet, it has been subjected internationally to the most villifying campaign of abuse and hatred by a large segment of the world because of a lack of understanding of its objectives.

So has American medicine.

Organized medicine is currently confronted with many problems and critics. Success or failure in responding to these depends on doctors' willingness to take an active, an aggressive part, not only in the practice of medicine as such, but also in the crucial administrative and organizational activities that so vitally affect the health care system.

If the present trend of apathy by the individual physician to the objectives of organized medicine continues, there will soon be no organized medicine. Then by default, direction of medicine will remain with the whims of the unscrupulous politician and the unprofessional bureaucrats administering the health agencies.

Robert E. Pennington

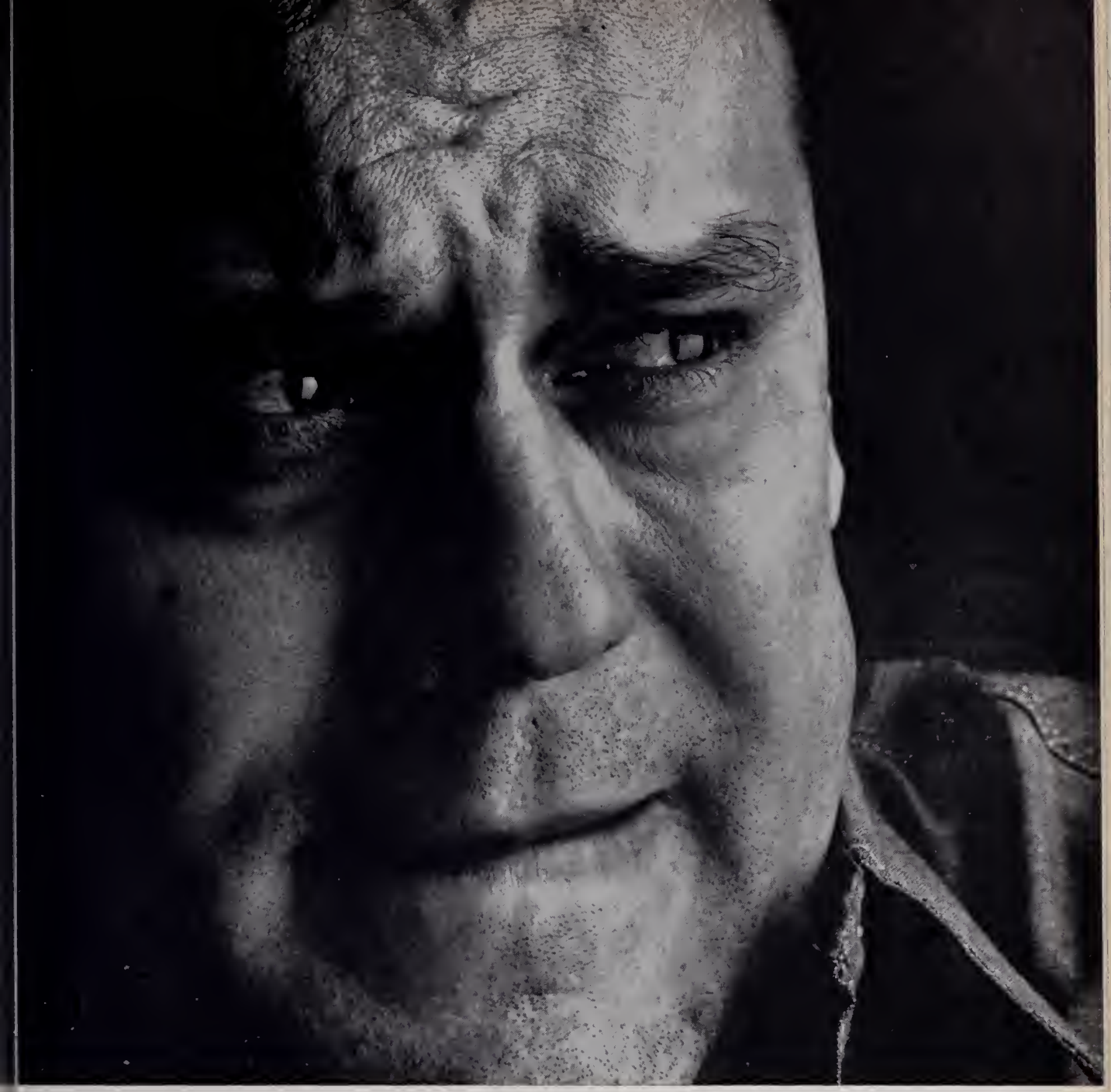


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Mike expects a penicillin injection. He's about to be pleasantly surprised.

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Indications: Infections due to pathogens susceptible to oral penicillin G. Prophylaxis of rheumatic fever in patients with previous history of the disease.

Precautions: Skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin-allergy may occur. Measures for treating anaphylaxis should be readily available: epinephrine, oxygen and pressor drugs for relief of immediate allergic reactions; antihistamines and corticosteroids for delayed effects. Penicillin may delay or prevent the appearance of primary syphilitic lesions. Patients with gonorrhea who are suspected of concurrent syphilitic infections should be tested serologically for at least 3 months. Where lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. As with other antibiotics overgrowth of nonsusceptible organisms may occur; if so, discontinue and take appropriate measures. Treat β-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

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... consolidates fluid stools with pectin
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and protects intestinal mucosa

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Parepectolin®

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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
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(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.
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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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oxyphenbutazone

helps osteoarthritic joints move again



3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964. 76.9% of 407 patients

Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966. 84.6% of 39 patients

Please see adjoining page for brief prescribing summary

TA-4919 PC

How long will it take her to recover from her hip fracture if she just doesn't care?



Does she really care?
s she alert, encouraged,
ɔsitive and optimistic
ɔout getting completely
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Or has she given in to
ıe demoralizing impact
f confinement, disability
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When functional fatigue
ɔmplicates convalescence,
lertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

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Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.
And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

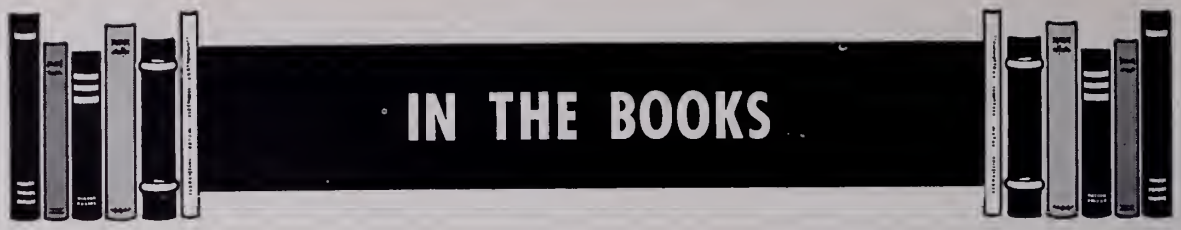
Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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Cincinnati, Ohio 45215



A MANUAL OF TROPICAL MEDICINE, Fourth Edition: by G. W. Hunter, Ph.D.; W. W. Frye, Ph.D., M.D.; J. C. Swartzwelder, Ph.D.; Published by W. B. Saunders Company, Philadelphia, 1966; 931 Pages; Price $18.50.

The revised, improved edition of this book has a formidable list of qualified contributors. It has a distinct Louisiana-Florida flavor due to the number of authors and contributors from this area.

The book is structured as a manual and it is not a detailed textbook. Most of the epidemiological diagrams have not been changed from the last edition, but current charts and new pictures have been added except for several diseases.

In a broad division by topics the first one-third of the book deals with infectious diseases, beginning with a most challenging section on virology. The middle third deals with a predominant field in tropical medicine, parasitology, and the remaining third presents sections on nutrition, entomology and laboratory procedures.

For a critical examination this reviewer felt the authors missed a real point of emphasis in failing to state that infectious hepatitis is the most common affliction of the foreigner living or visiting in the tropics. It is of greater potential danger than malaria at the present time. Also the Section on Diarrheal Diseases was far too brief. The space taken for the chart of serotypes found in the United States and the culturing procedures for salmonella and shigella could better be used to challenge men to more investigation of etiologies in the tropics. For one with an inquisitive mind, the new treatise on Kuru was of interest—but who would ever see this disease?

This manual should be of great usefulness primarily to those practicing in a tropical or subtropical climate and to teachers of parasitology and tropical medicine. For the physician newly drafted into the armed services, or the stateside practicing physician, it will be useful as a reference book in a library for their immediate referral when faced with a tropical disease.

Finally, each chapter has adequate references for more extensive study. The appendix is a very handy tool for the physician to locate the geographic location of these conditions.

G. Dudley Nelson, M.D., M.P.H. & T.M.

HANDBOOK OF OCCULAR THERAPEUTICS AND PHARMACOLOGY: by Philip P. Ellis, M.D., and Donn L. Smith, M.D., Ph.D.; Published by the C.V. Mosby Company, St. Louis, 1966; 197 Pages; Price, $9.75.

This small volume is an attempt to produce a concise ready reference for ophthalmologists and a guide to therapy for general practitioners and beginning residents. The authors generally succeed in this purpose, but at the expense of being somewhat superficial, which is understandable. There is very little information on the basic pharmacology of the various agents described, with the possible exception of the chapter on autonomic agents, which is a welcome addition to the previous edition. At the same time much excess wordage could have been avoided by elimination of many statements which should be self-evident to most physicians, such as a definition of contact dermatitis.

The first section, titled "Ocular Therapeutics" should be of value primarily to the general practitioner, as it contains practical therapeutic information which is familiar to most opththalmologists. The exception of this is the chapter on intraocular infections which contains most helpful tables on dosages of systemic, subconjunctival and intracameral antibiotics used in the treatment of bacterial endophthalmitis. This is fortunately a rare occurrence and thus one for which most ophthalmologists do not have the readily available up-to-date information which these tables provide.

The second section, titled "Pharmacology-Therapeutics Agents", contains some information on the basic pharmacology of various agents along with specific dosages, side reactions and contra-indications. This section is of value as a reference for ophthalmologists and as a source of general information for generalists. The tables of dosages and comparative potency of steroids, sulfanamides, antibiotics and vitamins are particularly helpful, as well as the section at the end concerning pediatric dosages.

In general, this book, although sparse in basic considerations and references, largely accomplishes its avowed purposes and should be of value to both the practicing ophthalmologist and general practitioner.

Robert J. Kaiser, M.D.

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. . . easily and quickly recorded on your office cardiograph

Auscultation and phonocardiography should complement each other in your clinical diagnoses — the former by helping you assess the musical and non-musical character of sounds and murmurs, frequency composition and variations . . . the latter by pinpointing the precise beginning and ending of sounds and murmurs within the cardiac cycle. Chart tracings of sounds, for example, may help identify points of occurrence and duration characteristic of certain innocent and pathologic murmurs . . . delineate the delay and first sound accentuation in mitral stenosis . . . or isolate the typically high-pitched murmur between the first and second sounds in aortic stenosis, which might otherwise appear pansystolic because of the low or inaudible intensity of the second sound. To further aid the precise determination of timing of sounds and murmurs, *combined ECG-PCG recording* will clearly reveal the location of the sound within the cardiac cycle. The Hewlett-Packard 1506A Heart Sound Amplifier enables you to do just that — in conjunction with a 500 Viso cardiograph or other 2-speed instrument with adequate frequency response. By electronically measuring and sampling the heart sound signal at a frequency within the Viso's recording capability, the 1506A permits diagnostic-quality PCG's to be recorded by the 500 Viso.

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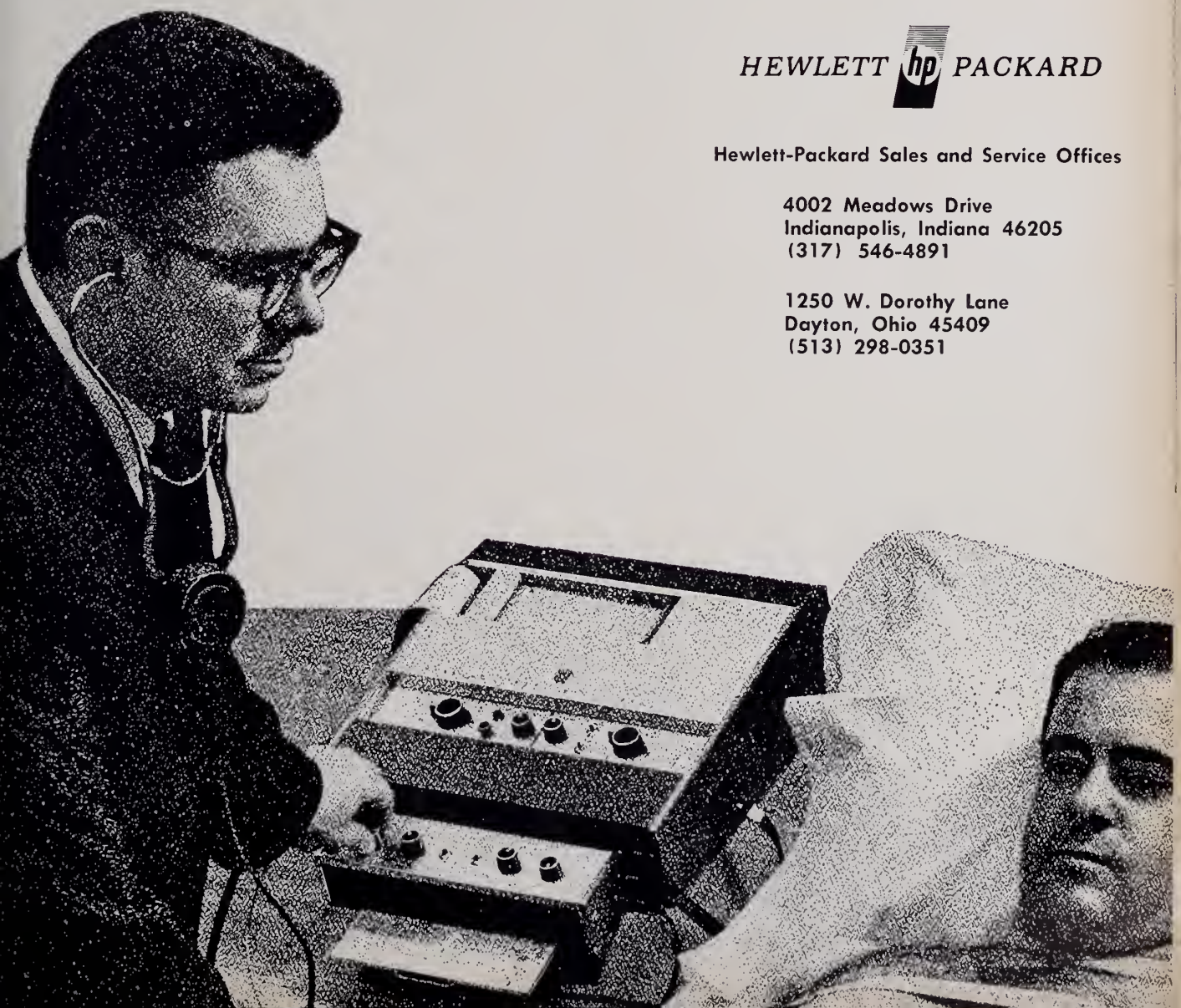
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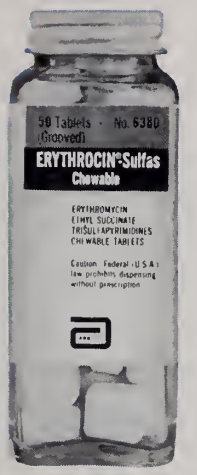
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In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

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Therapy was given from three to 12 days, with an average of six days.

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87 patients were treated[1,2]—all children, ages four months to 15 years.

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53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

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A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

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Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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CORRECTION

The Journal of the Kentucky Medical Association regrets the misinformation which appeared on this page in the March, 1967, issue. March 30 and 31 were the correct dates for the Thirteenth Annual Symposium on Cardiovascular Diseases, Brown Hotel, Louisville, sponsored by the Heart Association, Jefferson County Academy of General Practice, and University of Louisville School of Medicine, rather than April 29 and 30 as previously reported.

IN KENTUCKY

APRIL

19-20 KMA Interim Meeting, Ken-Bar Inn, Gilbertsville

20 U of L School of Medicine, in cooperation with the Ky. Chapter of the Arthritis Foundation, one-day Symposium on Rheumatic Diseases, "Osteoarthritis and Related Disorders, Rankin Amphitheater, Louisville General Hospital

22 Industrial Doctors and Nurses, Admiral Benbow Inn, Louisville (All day meeting)

24-27 Kentucky Hospital Association Annual Meeting, Louisville

MAY

1-5 Symposium on "Current Concepts in Chest Radiology: Pathophysiological Correlations," Department of Radiology, University of Kentucky Medical Center, Lexington

9-11 Fourteenth Annual Convention, National Geriatrics Society, Brown Hotel, Louisville

10-12 Sixteenth Annual KAGP Scientific Assembly, Convention Center, Louisville (Sheraton Hotel, Headquarters)

18-20 Kentucky Ob-Gyn Society, Annual Meeting, Continental Inn, Lexington

19-20 Symposium on Genetics and Birth Defects, Sheraton Hotel, Louisville

19-20 Eighteenth Annual Session Kentucky Surgical Society, Park Mammoth Resort, Park City

24 Kentucky Society of Internal Medicine Annual Meeting, Executive Inn, Louisville

JUNE

10 Conference on "The Hospital Emergency Room—1967: Problems and Proposals", Stouffer's Inn, Louisville

IN SURROUNDING STATES

APRIL

17-20 American College of Obstetricians and Gynecologists, Hilton Hotel, Washington, D.C.

19-22 Eleventh Annual Post Graduate Course on Fractures and Other Trauma, Chicago Committee on Trauma of the American College of Surgeons, John B. Murphy Auditorium, Chicago

24-26 AMA National Congress on Environmental Health Management, Hotel Americana, New York

26-27 Cleveland Clinic Educational Foundation, "Diabetes Mellitus: The Old and the New" Bunts Auditorium, Cleveland

MAY

3 American Cancer Society Symposium, "Current Concepts in Etiology and Diagnosis of Cancer," Sheraton-Dallas Hotel, Dallas

6 American College of Psychiatrists, Annual Meeting, Detroit

16-19 Ohio State Medical Association, Columbus

21-24 National Tuberculosis Association, American Thoracic Society, and National Conference of Tuberculosis Workers, Penn-Sheraton, Pittsburg

JUNE

3-4 AMPAC Annual Workshop, Sheraton Park Hotel, Washington, D.C.

12-22 American Medical Association Annual Meeting, Atlantic City

15-19 American College of Chest Physicians, Atlantic City

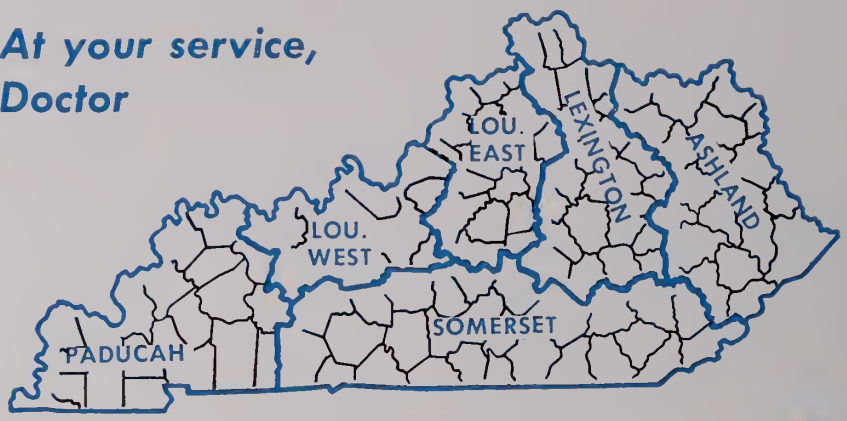
16-17 American Geriatrics Society, Claridge Hotel, Atlantic City

17-18 American Diabetes Association, Atlantic City

18-22 American College of Preventive Medicine, Atlantic City

26-29 American Orthopaedic Association, Hot Springs, Virginia

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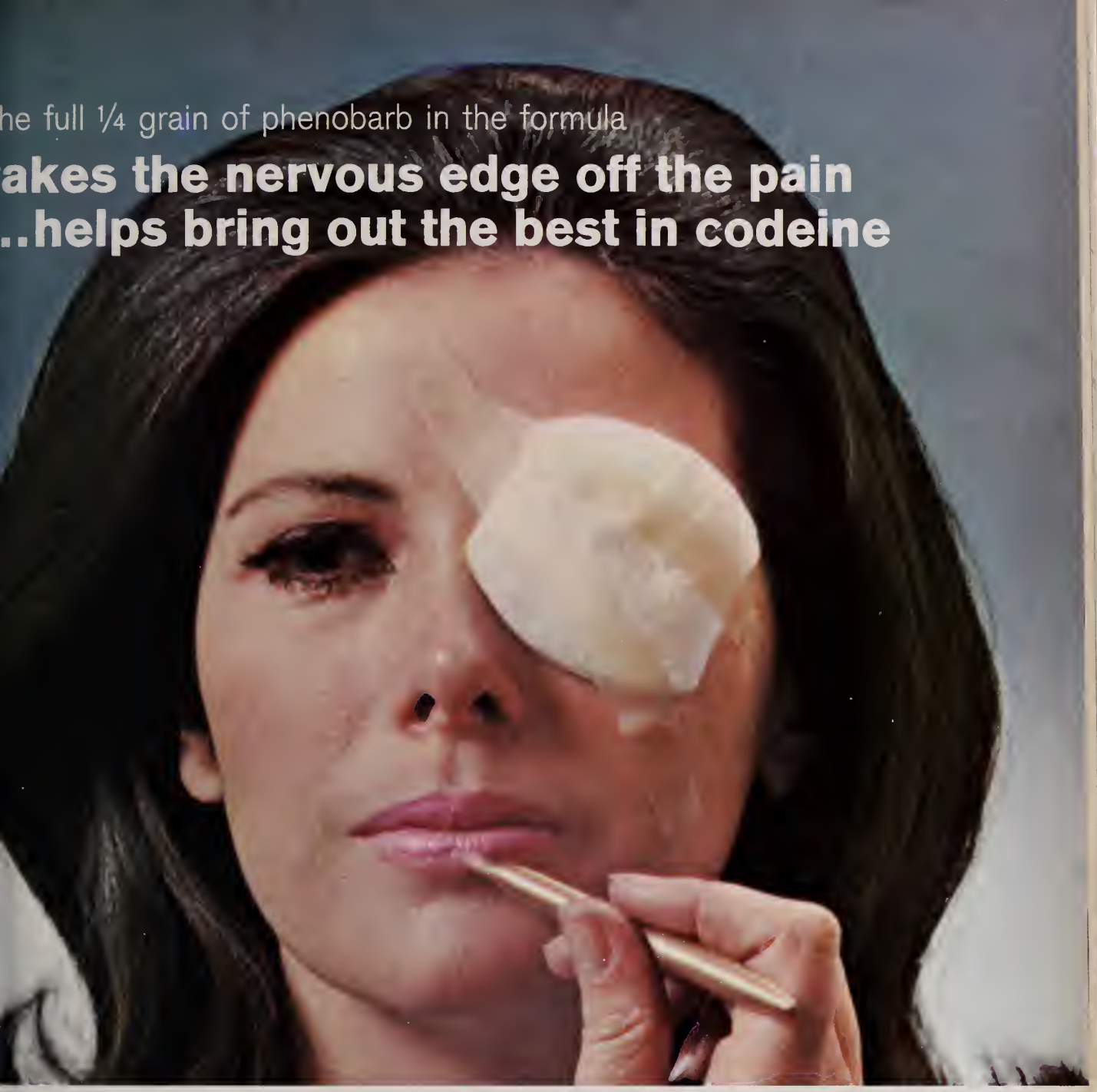
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Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

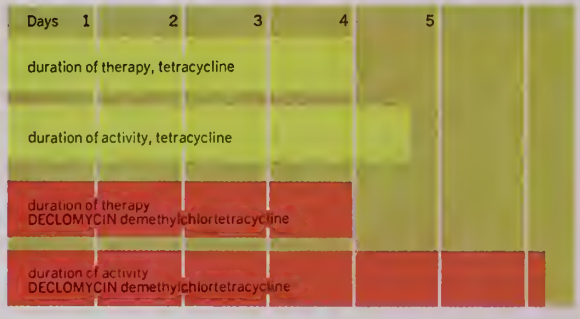
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Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measure should be taken. Use of demethylchlortetracycline durir tooth development (last trimester of pregnancy, neonat period and early childhood) may cause discoloration the teeth (yellow-grey-brownish). This effect occurs most during long-term use but has also been observed in sho treatment courses. In infants, increased intracranial pre sure with bulging fontanels has been observed. All sig and symptoms have disappeared rapidly upon cessatio of treatment. Side reactions include glossitis, stomatit proctitis, nausea, diarrhea, vaginitis and dermatitis. adverse reaction or idiosyncrasy occurs, discontinue me ication and institute appropriate therapy. Anaphylacto reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i. Should be given 1 hour before or 2 hours after mea since absorption is impaired by the concomitant adm istration of high calcium content drugs, foods and sor dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 m and 75 mg of demethylchlortetracycline HCl.

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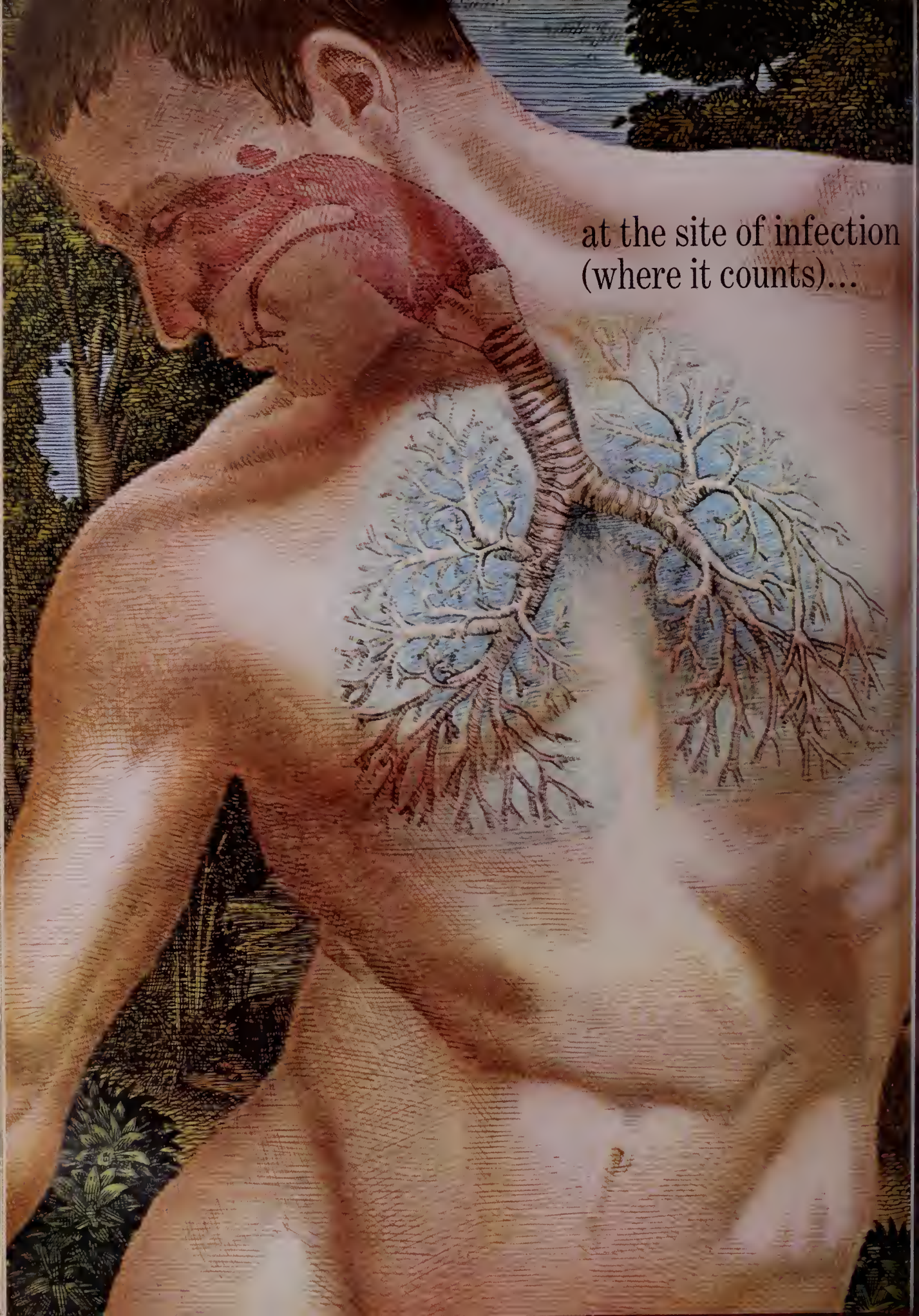
One rounded teaspoonful of Metamucil powder in a glass of cool liquid, or one packet of Instant Mix Metamucil in a glass of water. An additional glass of liquid is helpful.

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Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses c medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six months patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had epi of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mont rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Elev of SGPT and serum alkaline phosphatase levels during the c of treatment was observed in one patient treated with Il and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the pen group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients were parable to those in a similar control group who had rec penicillin.

Gastro-intestinal disturbances not associated with hepat fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hour children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushe swallowed with water.)

For adults and for children over fifty pounds, the usual d of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythro therapy should be considered.

In the treatment of syphilis, the recommended total dos 20 to 30 Gm. given in divided doses for a period of ten to f days. Close follow-up of the patient is necessary since er mycin drugs have not had adequate evaluation in all sta syphilis. Examinations of spinal fluid are recommended a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four da recommended. In the treatment of gonorrhea, patients v suspected lesion of syphilis should have a dark-field exami before receiving antibiotics, and monthly serologic tests s be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 2 (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to b in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in l size packages, with dropper calibrated at 25 and 50 mg.

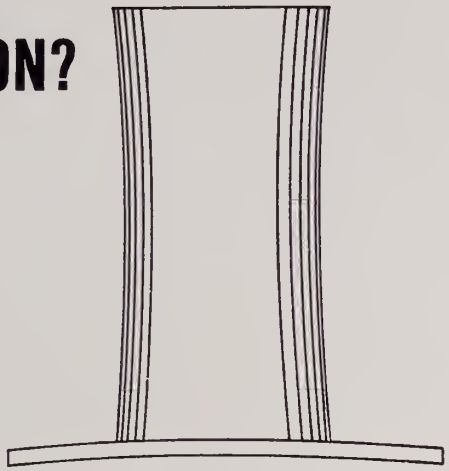
Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equi to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pac

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., 247:69
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., 12:398
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., 239:198,

Additional information available to physicians upon request.
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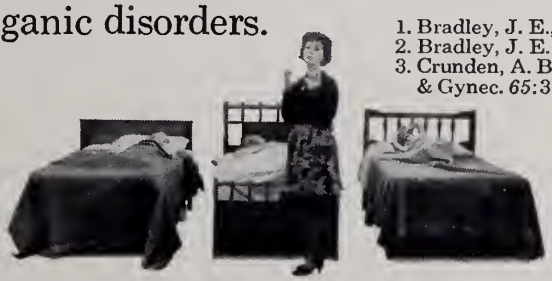
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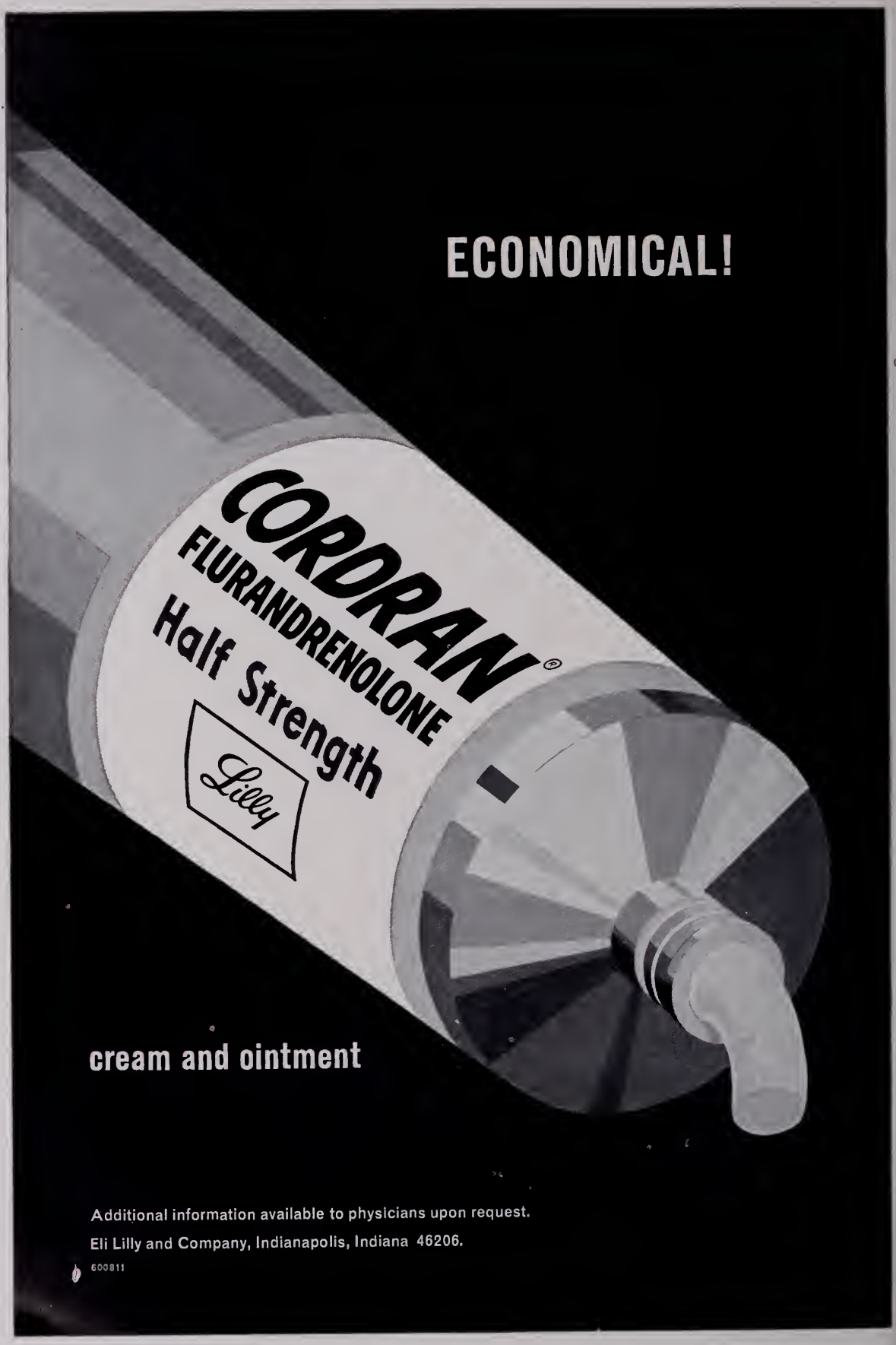
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Cancer Of The Large Bowel †

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Forty cases of cancer of the large bowel are reported and the problem is reviewed. The five year survival of the second most common cause of deaths in Kentucky remains at about 50%.

SINCE 1776, when Pilloré performed the first operation on the colon, surgeons have taken an active interest in this organ. Being rather easily accessible for removal of any portion or all of it the results of treatment of cancer of this organ are far better than those of the pancreas, adrenals, lungs and prostate. Cancer of the large bowel accounts for 15% of all cancer deaths, ranking with cancer of the lung and stomach as one of the most common types in both men and women. According to Colcock[3], in this country each year more than 30,000 patients die from this disease. According to Cole[6] 42,000 died of the disease in 1965. Yet, by surgery, we have a fighting chance for a cure of 45 to 50 per cent of these patients. If operated upon before the tumor has spread to nodes, the cure rate rises to 60 or 65 per cent. As symptoms occur rather early the survival rate is the highest among cancers of the gastrointestinal tract.

In Kentucky we find the following mortality statistics:

Leading causes of death in Kentucky 1964[12]:

1) Heart disease	11,626
2) Cancer	4,484
3) Vascular lesions of the C. N. S.	3,829
4) Accidents	2,108
5) Pneumonia	986

A breakdown of the cancer deaths is as follows:

1) Lungs	658
(494)	
2) Large Bowel	626
(132)	
3) Breast	390
4) Stomach	279
5) Prostate	270
6) Cervix and Uterus	264
7) Mouth and Pharynx	133
8) Esophagus	76
(G. I. Tract 1114	25%)

The literature on this subject is extensive and the list of surgeons who have made great contributions in this field is long. Why then do we still have only about 50% survival for 5 years or more? As in most cancer the answer lies in early removal before spread beyond the primary site has occurred. We have not yet arrived at the point of an annual barium enema on everyone as we try to do with mobile x-ray units for annual chest x-rays. We must depend on symptoms.

In considering cancer of the large bowel there has occurred to me a "Colon Cancer Triad" or rough "Rule of Three".

Etiology:

1. Adenomatous polyps: According to Coller[7] 15-30 per cent of polyps become cancer. According to Colcock[4] 70% of cancers and 50% of the polyps are in the

†*Presented before the Kentucky Surgical Society at French Lick, Ind., May 14, 1966*

rectum and rectosigmoid; cancer is 5 times more common in patients with polyps than without. 25% of patients who have cancer of the colon have associated polyps.

2. Ulcerative Colitis:
   Lyons and Garlock[13] found 3.9% of 226 cases of ulcerative colitis had cancer. They found that 36% of patients having the disease 12 years or more had cancer. Welch and Hedberg[24], in 750 cases, found 3.3% to have cancer. They stated that cancer was 6 times as common in chronic ulcerative colitis.
3. Congenital Multiple Polyposis:
   Dukes and Lockhart-Mummery[8] found 150 cancers among 208 cases of congenital multiple polyposis.

Symptoms:

1. Persistent vague abdominal discomfort or pain
2. Blood in the stool
3. Alteration in bowel habits which may go to obstipation resulting in complete obstruction. (In 1957 I read a paper before this society in which it was stated that 65 to 90% of colon obstruction was due to carcinoma[2]).

Diagnosis:

1. Colcock[4] and Swinton[22] say that one-half of all cancers of the large bowel can be reached by the examining finger. Others say two-thirds can be palpated in this manner.
2. Two-thirds of all colon and rectal cancers can be seen and biopsied by use of the Sigmoidoscope. In a series of 295 polyps Welch, McKittrick, and Behringer[25] found 73% to be within reach of the 25 cm Sigmoidoscope. Three cases malignant polyps in my practice were cured with this instrument, as well as a number of benign ones
3. The barium enema examination will usually locate the remaining one-third. It will show almost any lesion as small as 5 mms.

Treatment consists of the following

1. Decompression by cecostomy or colostomy (this would formerly have included as definitive treatment the exteriorization procedures of Paul, Bloch, Mikulicz and Fred Rankin)
2. Primary resection of a large segment with wide resection of node-bearing mesentery
3. Combined abdomino-perineal resection of rectum as described by W. E. Miles in 1908[16]

Distribution percentages:

	Pemberton & Dixon	Popper	Strode
Cecum	5.95%	8.3%	12.2%
Asc. & Transv.	16.99%	12.6%	10.3%
Left Colon	31.25%	29.1%	43.1%
Rectum	45.14%	50.0%	34.4%

Analysis of Cases:

Cancer of Large Bowel (40 cases)

Right colon	4
Mortality	0
5 year survival	1
Left Colon	19
Mortality	5
5 year survival	7
Colostomies	6
Primary Resections	13
None with colostomies survived 5 years	
Rectum	
Anterior Resections	4
Mortality	1
5 year survival	1
Abdomino-Perineals	9
Mortality	0
5 year survival	4
Malignant Polyps	4
Mortality	0
5 year survival	4
Total Operative Mortality	6(15%)
Total Survival	17(42.5%)
Cecostomy or Colostomy	9
Primary Resection	13
Primary Resection (no metastases)	10
5 year survival	7(70%)
Mortality	3

Prognosis

This depends on many factors, notably the limitation or extent of disease at time of surgery. Coller and associates[7] found 12.8% of a large series of cases not resectable at time of surgery. Of the remaining 87.2%, when the primary lesion was removed 26% had gross cancer that was irremovable. Therefore, only 61.2 per cent had a chance of a possible cure. This figure was further reduced

by microscopic study of regional nodes. Of this series the 5 year survival was 44.1. Cole[5] states that 35 to 40% of patients are incurable by the time they reach the operating room. Colcock[3] gives the Lahey Clinic survival rate at about 50%. Mayo and Lovelace[11] reported a 57% 5 year survival. McSwain et al[12] reported 45.5%. Welch and Burke[20] found at the Massachusetts General Hospital a 5 year survival rate of 68%. From 1937 to 1955 there was an increase of 15% in the survival rate in the descending colon and rectum. My own series shows 42.5% survival for 5 years or more.

Technical Aids

1) Preoperative preparation with drugs, enemas, diet, electrolyte balance and blood replacement is of great importance.
2) Thorough exploration of the peritoneal cavity for extension to adjacent organs, metastases, other primary tumors or other surgical lesions
3) Minimal handling of the tumor
4) Ligation of the colon above and below the tumor with umbilical tape before any surgery is begun, as advocated for many years by Warren Cole[4]
5) Ligation of vascular trunks before resection is begun
6) Irrigation of bowel ends before anastomosis is begun. Cole[5] uses half strength Dakin's solution, as does Poth. Colcock[3] uses 1-500 bichloride of mercury and has had no ill effects. Some British groups also use this solution. These solutions are thought to remove or destroy cancer cells.
7) Excision of bowel ends before sutures are placed
8) Interrupted silk or cotton sutures for the outer layer and interrupted or continuous cat gut for the inner layer, the bowel ends, of course, to be sutured without tension. In the low anterior resection of the rectum one layer of interrupted silk or cotton sutures is sufficient, since the rectum is not covered with peritoneum at this point.
9) Low midline incision for the Miles operation with the colostomy in the upper end of the incision, after the technique of Thomas E. Jones[9]
10) End-to-end ileotransverse colostomy in one stage for right colon lesions (although two-stage operations are indicated at times in seriously ill patients, as pointed out by C. C. Johnston[8])
11) Thorough dilation of the anal sphincter at the end of a colon resection, with the daily instillation of 4 ounces of normal saline, as advocated years ago by A. W. Allen[1]
12) Make every effort to relieve obstruction when present without a colostomy. Use such measures as nasogastric suction, enemas, and introduction of tubes and catheters through the sigmoidoscope, as I was able to do in one case which has now survived 12 years. A colostomy, which is necessary at times, carries an added morbidity, calls for 3 operations and adds great expense and hospitalization, as shown by 2 cases:

    J. P. H.: Cancer descending colon, one stage resection, hospitalized 13 days, total cost $442.30

    O. S.: Cancer descending colon, obstructed, had colostomy, resection and closing of colostomy, hospitalized 82 days, total cost $2,025.86
13) Chemotherapy; Nitrogen mustard or more frequently 5-FU, has added little or nothing to the survival rate of cancer of the colon and rectum. Rousselot et al[16] in 1965 reported some favorable results with intraluminal adjuvant therapy at the time of operation on the colon and rectum in 154 cases, using nitrogen mustard or 5-FU.

Case Reports

Seven cases have been chosen to illustrate the clinical picture, the treatment of cancer and the results of treatment in different areas of the large bowel.

Case 1. Mrs. S. G. aged 84 was seen with a history of vague pains in the abdomen and right side of several weeks duration. Examination revealed a mass in the right lower quadrant. Barium enema showed a large filling defect in the cecum. Anemia with 2.5 million RBCs was present and blood was present in the stool. After several

transfusions she was operated upon and a moveable mass was found and no metastases were noted. An ileotransverse colostomy, end to side, was performed. Two weeks later a second operation was done consisting of a resection of the right colon. Convalescense was complicated by a fistula from the stump of the transverse colon. This closed after six weeks. The patient lived to the age of 93 without evidence of metastases and in good health.

Case 2. Mrs. J. B. aged 60, gave a history of vague pains in the right side for several months, together with weakness and loss of appetite. Hemoglobin was 60 and RBCs 2.8 million. X-rays of colon revealed a defect of the cecum with narrowing of the lumen. A palpable mass was present. After preparation with Sulfasuxidine and Neomycin she was operated upon. A large tumor of the cecum was present with extension to the right ovary, and also a mass in the gastrocolic omentum above the transverse colon. The right colon, ovary, tube and omental mass were removed and an end to end ileocolostomy was performed. Path. Report: Adenocarcinoma with metastases to right ovary and regional nodes. Her convalescence was uneventful but she died 8 months later of widespread metastases.

Case 3. Mrs. L. L. aged 74 was admitted with severe cramp-like pains in the abdomen and no bowel movement for three days. There was only moderate distention. Flat plate revealed partial obstruction of the left colon. Sigmoidoscopy revealed at 20 cms. a tumor with marked narrowing of the lumen. Biopsy was taken and a catheter was passed through the opening by means of the sigmoidoscope. Biopsy revealed adenocarcinoma of colon. After 8 days of preparation she was decompressed and a resection of the descending and sigmoid colon was performed. No metastases were noted. The anastomosis was examined several times with sigmoidoscope. She is alive and well 12 years after surgery.

Case 4. J. P. H., male age 78. Complained of bleeding 2 or 3 times on defecation over the past few months. No pain. No change in bowel habits. Examination negative except for a few hemorrhoids. Rectal and sigmoidoscopic negative. Barium enema revealed a lesion in the sigmoid colon. After preparation with Neomycin and Sulfasuxidine on 5/19/61 a primary resection was done. Path. Diagnosis: Adenocarcinoma with negative nodes. He was discharged on the 13th P. O. day. Repeated follow-up examinations have been negative. On 12/23/64 an acute appendix was removed and there was no sign of cancer. He is well and 83 years of age.

Case 5. Mrs. H. G. aged 75 was seen complaining of bleeding from the rectum at intervals for about a year. A lesion could not be felt by the finger but one was easily seen with the sigmoidoscope at 14 cms. and biopsy revealed carcinoma. At operation no metastases were found and an anterior resection of 24 cms. of the rectosigmoid was performed. Repeated checkups have been negative and she appears in good health 4 years after surgery.

Case 6. L. P. a man aged 64 was seen because of bleeding from the rectum for 3 or 4 years. One year ago he noticed blood, pus, and mucus in his stools. He had had hemorrhoids for several years. He was treated by a chiropractor for some time and was finally seen by a physician who made the diagnosis and referred him to me. He also complained of weakness, lassitude and poor appetite. In addition to his hemorrhoids he had a large fungating mass just above the prostate which proved to be an adenocarcinoma Grade II. A Miles abdomino-perineal resection was performed with a midline colostomy. No metastases were seen. In the mucosa of the specimen there were several polyps, some above and below the tumor. Section of some of the polyps also showed cancer. His recovery was uneventful and he is alive and well

16 years after operation at the age of 80. He has required 2 slight revisions of his colostomy.

Case 7. Mrs. A. R. age 50 was first seen on 4/20/62 with a history of rectal bleeding one time with bowel movement 2 months previously. It recurred 5 days before this examination. No diarrhea, constipation or pain. Examination negative. Sigmoidoscopy negative. Barium enema negative. She was next seen 3 months later because of continued occasional blood and mucus streaked stools. After 2 more barium enemas one reported a probable polyp in the sigmoid. As much on the history as on the x-ray, an exploratory laparotomy was performed, the lesion was located, a colostomy was done and the lesion excised with a fairly wide base. Path. report was villous adenoma with carcinoma of the distal portion. No further symptoms have occurred and barium enema November 1965 was negative.

Summary

1) Death from cancer is second only to heart disease in Kentucky. There were 4,484 deaths from cancer reported in 1964. Cancer of the colon and rectum, which were second to cancer of the lung, accounted for 626 deaths. In the United States there were more than 40,000 deaths from cancer of the large bowel during the same period.

2) Our operative mortality has improved from 41.6%, in William Ernest Miles' first report in 1908[16], to a respectable 4 to 6 per cent (1 to 4 according to Coller[7]).

3) Our survival rate has not improved much in the past 15 years, remaining at about 50 per cent. This is due to the fact that the average length of time of the disease is one year before surgery: About 30 to 40 per cent of cases are not curable at the time of operation. In several series of resectable cases there is a 60 per cent survival rate.

4) Survival rates will be improved if physicians maintain a high index of suspicion, for the diagnosis is relatively easily made by rectal examination, sigmoidoscopy and the barium enema.

5) Symptoms of blood in the stool, alteration in bowel habits, abdominal pain or discomfort of any sort are causes for suspicion.

6) Obstruction requiring colostomy increases morbidity and decreases the survival rate.

7) This paper is based on a study of 40 cases operated upon by the author.

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Epithelial Papilloma Of The Nasal Cavity

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Much confusion exists about the malignant potential of nasal epithelial papilloma. A case of squamous carcinoma in one of these lesions is presented. The potential of these lesions to recur and become malignant is emphasized.

MUCH confusion exists in the literature regarding the malignant potential of the epithelial papilloma of Ewing (Schneiderian papilloma or inverted papilloma). The following report emphasizes the association of malignancy at the time of initial resection.

Case Report

This fifty-five year old white male was seen in the office in November 1954, complaining of nasal obstruction. He had difficulty in breathing through his nose most of his life. Sinus surgery was done on the right side of his nose in 1948. He did not know what was done. No relief was obtained.

Examination revealed a large, firm, reddish-gray papillary mass filling the posterior part of the right nasal cavity. It was too large to determine its point of attachment but it appeared to be superior. With a nasopharyngoscope inserted through the opposite side of the nose it could be seen extending into the nasopharynx.

A small biopsy was taken and was reported as nonspecific epithelial acanthosis. A larger biopsy was taken one week later with the report being "Inverted squamous papilloma." (Fig. 1) The patient was admitted to the hospital two weeks later for removal of this apparently benign lesion.

Surgery was done under general endotracheal anesthesia. The mass was removed cleanly and relatively simply through the nose, using a nasal snare and ethmoid forceps. It was removed in four or five large pieces primarily by avulsion after use of the nasal snare. (Fig. 2) The tumor had a relatively small stalk attached to the superior posterior part of the right nasal cavity. Bleeding was minimal and packing was not necessary. Microscopic study revealed a squamous cell carcinoma arising centrally in an epithelial papilloma. (Fig. 3)

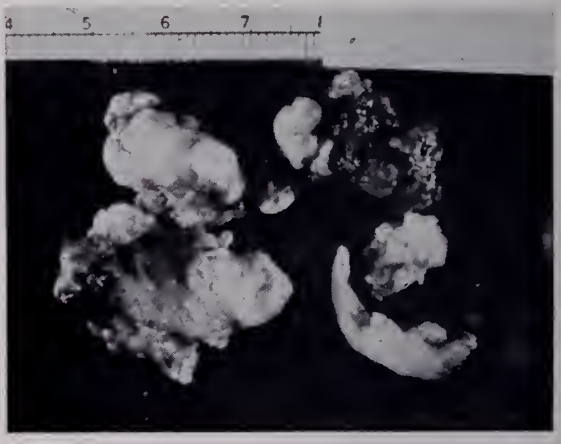


FIGURE 1. Photomicrograph of Epithelial Papilloma having inward growth of epithelium. X 40

In view of this finding, the patient was given cobalt radiation therapy. He received five thousand tissue roentgens in five weeks. Follow-up examination two weeks later revealed a small amount of evident residual tumor tissue in the sphenoethmoid area. It could now be seen that an ethmoidectomy and partial removal of the middle turbinate had been done in 1948.

He recovered uneventfully and during the next three months the tag of tumor tissue disappeared.

He was last seen in November 1965, at which time no evidence of tumor could be found. His cervical glands were not enlarged and he had no complaints.

Discussion

The epithelial papilloma of Ewing charac-

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teristically has origin in the nasal Schneiderian mucosa with occurrence most commonly in the adult male. The site of involvement is usually from the middle turbinate toward the posterior portion of the nasal cavity.[1] This neoplasm is to be differentiated from the exophytic papilloma arising in the septum. The exophytic papilloma is usually small and papillary whereas the epithelial papilloma is usually larger, with less papillation and with a tendency of the epithelium, as may be seen, on microscopic study, to grow inward along ducts and sometimes, depending on the plane of section, to appear as stromal invasion. Both lesions may have transitional, pseudostratified columnar, or squamous epithelial covering. Recurrence is common in both lesions, however,

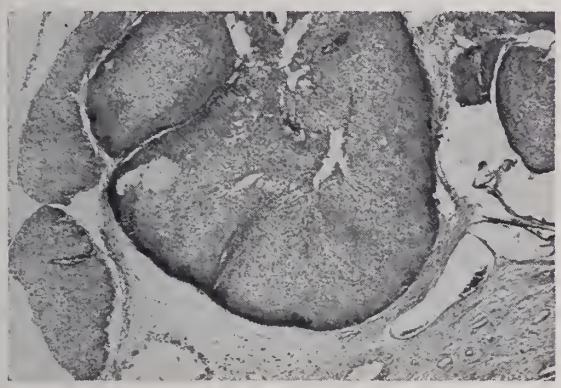


FIGURE 2. Gross appearance of surgically excised Epithelial Papilloma.

in a recent review malignancy was not associated with the septal papilloma whereas 20% of the epithelial papillomas presented histologic malignant change. In this study it was noted that malignancy, as in our case, is present at the onset with no significant tendency for malignant change with repeated occurence[2]. Further review of the literature indicates a difference of opinion concerning the malignant potential of these lesions. Some authors emphasize their malignant potential and

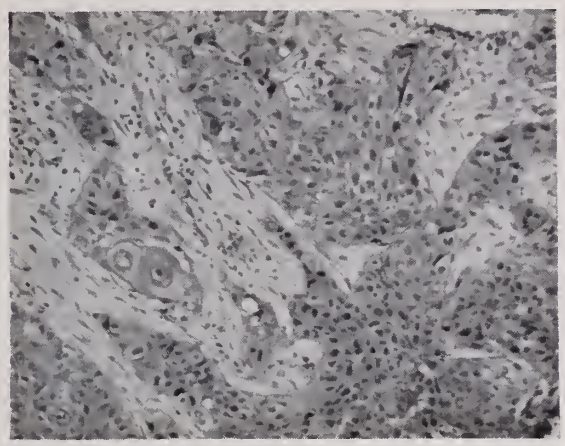


FIGURE 3. Photomicrograph with focal area of invasive squamous carcinoma. X 240

feel all should be treated as a low-grade transitional cell carcinoma.[3] Others state that malignancy in these lesions is infrequent and a high recurrence rate is the main problem in management.[4,5,6] The consensus is that malignancy is not unusual but metastases are rare. In one large series no lesion on follow-up had metastatic disease.[7] All authors agree on the great potential for recurrence and consider complete surgical excision mandatory to circumvent this tendency.

Summary

A case of squamous carcinoma arising in a nasopharyngeal epithelial papilloma is presented. The potential of these lesions to recur and to be associated with malignancy is emphasized.

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Some Uncommon Drug Eruptions†

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To the patient, any drug eruption is uncommon. Ofttimes, many uncommon drug eruptions may become common. An illustration of this is the increasing incidence of melasma from the oral ovulation suppressive medications. Other uncommon drug eruptions include reactions to intra-arterial injections of B_{12}, the new parameters of the photodermatitis and the uncommon reactions from occlusive dressings of topical corticosteroids.

IN DISCUSSING drug reactions, one must be aware of the continued fears and anxieties remaining from the Thalidomide hysteria. This is so even though Thalidomide continues to be used in cancer research and Hansen's Disease (leprosy). At the recent meeting of the American Medical Association in Chicago, there was, at least among the exhibits, a great emphasis on drug reactions. It is not realized by patients, political figures, and sometimes even doctors, that no drug, if it is a good drug, is without serious reactions. A notorious reactor, including causation of severe hemorrhages and even fatal reactions, has been and probably will continue to be for sometime, acetyl salicylic acid or aspirin. Yet, no one has as yet moved to take this drug from the market or even restrict it to prescription use or abuse.

Any drug, of course, may cause uncommon reactions. Drug eruptions vary from simple pruritus or even only so-called drug fever to severe major reactions with death. The skin is probably the commonest target organ, as Baer has indicated. The major reactions here include the vesicular, bullous, petechial, erythrodermic types and fatal anaphylaxis. The type of reaction, of course, depends upon the drug, itself, the manner in which it was given, either topically, parenterally, orally, or by suppository, and the responses of the patient.

Types of Reaction

In brief, reactions may be classified as modified after Baer:

1. over dose—such as hemorrhages from anticoagulants;
2. cutaneous allergic—such as penicillin rashes;
3. cutaneous toxic—as photodermatitis from Declomycin®;
4. visceral allergic—as visceral urticaria;
5. visceral toxic—hepatitis and nephropathy;
6. pharmacologic—ichthyosis — cataracts from Triparanol (MER-29);
7. biotropic—herpes simplex from phenobarbital "erythema of the ninth day!"
8. disturbances in normal body flora—such as overgrowth of yeasts with the use of broad spectrum antibiotics.

In order to limit such a vast section, such as our subject is, to some drugs of pertinent interest now, only a few examples of unusual reactions will be mentioned. First, it is well to remind the physician that as soon as a needle and syringe are used, reactions can develop. Systemic reactions from such an injection may vary from near syncope to shock or to fatal reactions. Ofttimes, it is not clear as to what the mechanism is. Such is the problem when one attempts to analyze reactions to injections of intralesional and sublesional

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corticosteroids which can produce syncopal episodes or fatalities. The possibility of inadvertent intravascular injection of the insoluble suspension of corticosteroid is discussed more frequently than proved. This is true even with the stories that such intralesional injections into the anterior scalp for the treatment of the localized hair loss in alopecia areata, has produced blindness.

The local reactions on injection may be similarly minimal or severe.

Panniculitis from intramuscular injections still occurs no matter with what medication. A recent case of suppurative panniculitis with chronic draining sinus from Phenergan® was observed. Accidental intra-arterial injection of medication, more common in years when injections were given more frequently, as in the treatment of syphilis, occasionally may occur. One such reaction was observed in a patient from an intra-arterial injection of B_{12}. Racemose patterns of redness spread over extensive areas of the buttock in which the injection had been given.

Some features of oral medications with unusual reactions which are significant today are, curiously, related directly and indirectly to light exposure. These are, in brief, the photodermatoses which develop from oral drugs, especially the tranquilizers, antibiotics and topical medications, and the disturbances of pigmentation, now becoming more common, from the use of the oral ovulation-suppressive medications. The difficulties of forecasting such potentialities by in-usage testing routine on trial groups, are real and significant. One must have the reactive patient, adequate sun exposure, and a knowledge and experience of photo testing. However, it took but a brief interval after the introduction of Declomycin to establish its excellent photosensitizing property. At times, such reactions can be forecast by the so-called photo-patch-test technique. For this, the material to be tested is put on the skin and exposed to sunlight or to light of the same wave length as the absorption spectrum of the medication. Sometimes the patient is exposed deliberately to the sun and the reaction on the exposed skin evaluated. The various parameters of the testing for photodermatitis are certainly not clearly defined as yet. So now, photo testing is added to the usual routine of techniques for evaluating or, rather, attempting to evaluate toxicity and sensitivity of a drug.

Melasma and the Pill

Another disturbing condition which is becoming more common, is the melasma introduced by the oral ovulation-suppressive medications. This may be called the "mark of the Pill" even though she may not wish it known she is taking the Pill. All sorts of combinations have been observed in our patients. The patients may develop this shortly after starting the drug, they may have taken it for years and then suddenly develop this hyperpigmentation, or they may have stopped the Pill when the hyperpigmentation developed and yet the hyperpigmentation continues for years. We would agree that those women who have had the chloasma of pregnancy are more apt to get the melanosis from such medication than the patient who did not have chloasma. Sometimes these cases can be very disfiguring with the added insult of hyperpigmentation from the sun. Occasionally patients who state that they have never had the Pill and never been pregnant develop the typical "mask of pregnancy." It is well to consider this mark of distinction as indicative of taking the Pill until proved otherwise.

The therapy of this condition is difficult. The two basic features are protection from the sun by use of sun protectants and the attempt to bleach by the use of the hydroquinone preparations. In our experience, these results are only partially, if at all, successful. In recent months we have been attempting to correct this condition after cessation of the use of these pills by dermabrasion, chemabrasion and experimental studies with laser impacts to remove this color.

Another uncommon form of pigmentation is that from the use of the phenothiazines, especially after prolonged use. Here, a bluish-black pigmentation of exposed skin develops. This should be differentiated from the photodermatitis of these drugs. Zelickson believes this pigment may not be melanin but a drug metabolite or pseudomelanin or some other pigment.

Topical Medications

Topical medications continue to produce drug eruptions and always will. Before dime-

thyl sulfoxide (DMSO) was removed from investigative studies because of the development of eye changes, it produced some reactions. It is a superior vehicle, one of the best vehicles we have had for topical medications. However, although of a low order of systemic toxicity it produced significant changes in the epidermis, dermis and perhaps in the blood vessel wall. Curiously, when DMSO was used as a vehicle for topical corticosteroids, such as fluocinolone, this irritant property of DMSO did not interfere but actually increased with the anti-inflamatory property of the fluocinolone. The unusual reaction from topical fluocinolone is the development of striae in the skin. These have come, in our experience, in the crural area in males or lower legs in some girls. It is true that such striae develop commonly about the hips especially around puberty or shortly afterwards and especially in individuals becoming obese rapidly. We would agree with the other investigators, that topical corticosteroids can induce such straie and these are, of course, permanent. We have observed such straie from topical DMSO-fluocinolone 0.025%.

With the use of occlusive dressing techniques, in which an impermeable material is placed over the topical corticosteroid, absorption is enhanced considerably. A recent innovation has been the use of crystals of the corticosteroid, fluorandrenolone, spread on Blenderm 3M adhesive tape. This has been an effective medication for localized areas of those skin conditions response to topical corticosteroids, such as, psoriasis and neurodermatitis, and for which the tape may be fitted. This medicated tape may be left on for 24-48 hours. Reactions to the tapes with irritation, sensitivity and heat reactions may occur.

The physician has often the difficult job of attempting to diagnose reactions to a drug or drugs in a patient who has had most of the pharmacopeia. It is difficult to attempt to guess except for some of those drugs which have characteristic reactions. These drugs, with their characteristic reactions are: the atropine group—scarlatiniform rashes; the corticosteroids—Cushing's syndrome, acne, seborrhea; sulfonamides and barbiturates—localized bullous eruption or fixed drug eruptions; the tranquilizers, antibiotics, (including griseofulvin), and the diuretics—photodermatoses;

(Continued on page 418)

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Abdominal Pain Due To Filariasis†

HENRY EVANS, M.D.*
Harlan, Ky.

A resident physician, native of India, was found infested with the filarial parasite, Wuchereria Bancrofti, and successfully treated. The main features of the disease are reviewed.

ON THE evening of March 6, 1966 a patient was seen in the emergency room of the Harlan Appalachian Regional Hospital at Harlan, Kentucky because of obscure abdominal pain. The cause of the pain turned out to be an infestation with the filarial worm Wuchereria Bancrofti. It is unusual to find a patient with filariasis in this country. Upon reviewing some of the literature we found that there had been little interest in filariasis for several years. There were reports of a few patients with filariasis treated since World War II. Edward Markell[1] reported, in December 1964, five patients with filarial infections, seen in a California clinic. Kevin Cahill[2] reported, in 1963, three patients with filariasis treated by him in a New York general hospital.

A few cases have been reported[3,4] in which an excised nodule was found to show fragments of the filarial worm. These have usually been caused by Dirofilaria, the common heart worm of the dog.

Case Report

Our patient was a young male physician, a native of Bihar in Northeastern India, who had come to this country in December 1965. On the evening of March 6, 1966, he was seen because of intermittent, crampy abdominal pain which had been increasingly severe since about 1:00 p.m. that day. He had no nausea or vomiting, and although he had had three bowel movements, they seemed unrelated to the pain. He had not eaten any unusual foods nor did he have any known food intolerance. Our initial questioning did not reveal any past illness. He did not smoke or drink.

Examination revealed only a thin, mildly dehydrated man who appeared to be in pain. He wanted to sit leaning forward. His abdomen was soft and the bowel sounds were quiet. He was quite tender in the upper abdomen, but there was no scrotal mass or tenderness, and rectal examination was negative except for a faint trace of blood.

After the initial examination, he was given symptomatic treatment and allowed to return to his room.

He rested fairly well until about 2:00 a.m. when he again had severe abdominal pain. Physical examination showed the same findings. The patient was admitted to the hospital.

The initial laboratory tests showed that the hemotocrit was 42%, the white blood count 10,000 and the differential count 49% segmented forms, 37% lymphocytes and 13% eosinophils. The urinalysis was negative. A flat film of the abdomen revealed minimal reflex ileus.

The following morning further laboratory tests were done. A repeat white blood count was 12,400 cells per cubic mililiter of which 57% were segmented forms, 34% lymphocytes and 7% eosinophils. Serum bilirubin was 0.52 mg. per 100 ml. Chest x-ray and E.K.G. were normal. Upper gastrointestinal series and gallbladder x-rays were negative.

We were struck by the persistent eosinophilia and suspected a parasitic infestation. Review of the history revealed that the patient

†*Presented at the Specialty Group Meeting of the Kentucky Chapter, American College of Physicians, during the KMA Annual Meeting, September 20, 1966 in Louisville.*

**Department of Medicine, The Daniel Boone Clinic, Harlan, Kentucky.*

had had a slight scrotal swelling about two years previously when he was in medical school. He had had no further investigation and no further signs or symptoms had developed. He had thought no further about the possibility of filariasis.

The day after admission the patient was discharged, but he was asked to return to the laboratory at midnight so that blood smears could be made to look for microfilariae. They were easily demonstrated.

The Parasite

The reproduction of the parasite shows the characteristics of the microfilariae or prelarvae. They are about 250 X 10 micra when fully developed. The columns of nuclei are anlagen of various organ systems. Identification is based on the position of these organ precursors and the position of the caudal nuclei. The microfilariae of Wuchereria Bancrofti show a cephalic space equal to the diameter of the head. The last five percent of the body, the tail, has no nuclei. (Figure 1.)

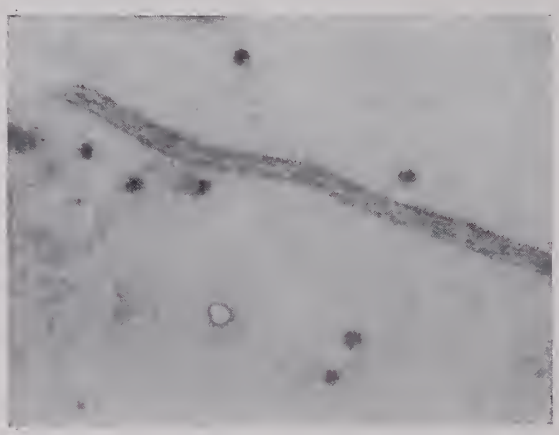


FIGURE 1. Microfilaria of Wuchereria Bancrofti.

The reservoir of the parasite is man. In endemic areas the microfilaria of Wuchereria Bancrofti appear in the peripheral blood in greatest numbers at night, from 10:00 p.m. to 2:00 a.m. The cause of this nocturnal periodicity is not known.

The microfilariae are ingested by species of Culex, Aedes, Anopheles and Mansonia mosquitoes. A common vector is Culex fatigans. Man appears to be easily infected, but animals are infected only with difficulty.

The ingested microfilariae pass through the gut wall to the thorax and mouth parts of the mosquito and become infective in two to three weeks. The infective larvae are passed into the skin with the bite of the mosquito, whence they make their way to the lymphatics where they mature. Continued reinfection appears necessary for the full clinical picture. There is no racial immunity but some acquired resistance develops.

The Disease

There are two main manifestations of the disease: inflammatory and obstructive. Immunosensitivity reactions play an important part in the pathogenesis of certain features of the disease. The inflammation is variable in intensity and in distribution. Acute lymphangitis and lymphadenitis develop in areas which later show obstructive changes. The patient is sometimes febrile and the lymphangitis may be intensely painful. The commonest areas of involvement are the superficial vessels of the extremities, testes and cord. Inflammation of the abdominal lymphatics may present a clinical picture resembling an acute abdomen. This is what we think happened in our patient.

Obstructive changes develop where inflammatory reactions have occurred. Lymphedema of the scrotum, hydrocoele and ascites occur. The enormous and grotesque enlargement of parts which may occur have, of course, given rise to the name "Elephantiasis."

In endemic areas filariasis is usually the accepted cause of hydrocoele, orchitis, and elephantiasis, but, of course, other inflammatory and obstructive disease of the lymphatics could cause similar changes.

The diagnosis is usually made on blood examination. The microfilariae are usually easily seen on wet preparation of freshly drawn blood. Thin and thick smears for Giemsa and Wright's stain are prepared for permanent slides.

The only effective drug for treatment is diethyl-carbaniazine (Hetrazan, Banocide), which we used in a dose of 2 mg. per kilogram of body weight, three times daily for 21 days. Repeated blood studies have since been negative for microfilariae. For this our patient has been very grateful, but the teachers of parasitology in our area have been somewhat upset that we have dried up their teaching slides.

This experience suggests that in our jet age world we should be a little more careful to obtain a detailed geographic history, especially when dealing with patients who are mis-

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SPECIAL ARTICLES

Disaster In Lexington†

RICHARD B. MCELVEIN, M.D.*

FLASH—LEXINGTON, KENTUCKY, 0900 30 OCTOBER, 1966 *A LARGE MILITARY PLANE HAS JUST CRASHED INTO THE CITY-COUNTY HEALTH BUILDING, WALLER AVE. ESTIMATED CASUALTIES, 250.*

WITH these words on a crisp, clear fall Sunday morning, a mock disaster was initiated which over the next one and one-half hours would involve some 650 people in an exercise designed to test the plans and capabilities of the Lexington-Fayette County Civil Defense authorities, the City and County Police and Fire Departments, the Fayette County Medical Society, and the four participating hospitals: Central Baptist Hospital, Good Samaritan Hospital, St. Joseph Hospital, and the University Medical Center.

Previous small disaster exercises had been carried out by individual hospitals and also on a combined basis. This exercise, however, was designed to provide a large number of casualties and to severely load the facilities of the community. The situation chosen was a large military plane crashing into the City-County Health Building while school children were receiving immunizations and the 250 casualties were obtained from the ranks of local boy scouts, girl scouts, and willing high school and university students. Moulages depicting injuries had been applied to some of the casualties while the majority were tagged to indicate the specific type of injury they had sustained.

The key to the evolution of the Disaster Plan is the Lexington, Fayette County Civil Defense radio net, in operation 24-hours a day; 7 days a week, propagated by short wave radio sets installed in all the general hospitals, all city fire stations, the City Police Department, the Red Cross, the U.S. Weather Bureau, the County Patrol, and the County Fire Department with the control station located in the Lexington Fire Department. Activation by the radio net is the stimulus to the individual units to commence their disaster plans. Somewhat embarrassingly, this transmission was picked up, due to superb atmospheric conditions, by monitoring stations in Louisville and it was not until they received verification that this was a mock disaster that they ceased their preparations towards assisting their sister city in difficulty.

The Fayette County Medical Society plan calls for 8 physicians notified by the Physicians Exchange to report to the Disaster area at once and serve as advanced triage physicians. They determine the extent of the injuries, the number of casualties, the availability of physicians in the respective hospitals in the city and then ensure a smooth orderly flow of patients to the approximate and not necessarily the nearest hospital. It has been found to be important to know what type of physicians are available in which hospitals so that for example head injuries are sent to a hospital where a neurosurgeon is present rather than to another hospital where there may not be a neurosurgeon present.

(Continued on page 420)

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†*The KMA Disaster Medical Care Committee members encourage communities to test their disaster plans. This is a report on such a test held in Lexington. Other Kentucky communities are conducting similar exercises.*

**Assistant Disaster Chief for the Fayette County Medical Society at the time of the mock disaster exercise; presently serving as secretary-treasurer of the Society.*

New
low-cost tetracycline/antifungal therapy

for broad-spectrum activity
plus specific antifungal prophylaxis
at significant patient savings

Whenever tetracycline is indicated in these candidates for Candida:

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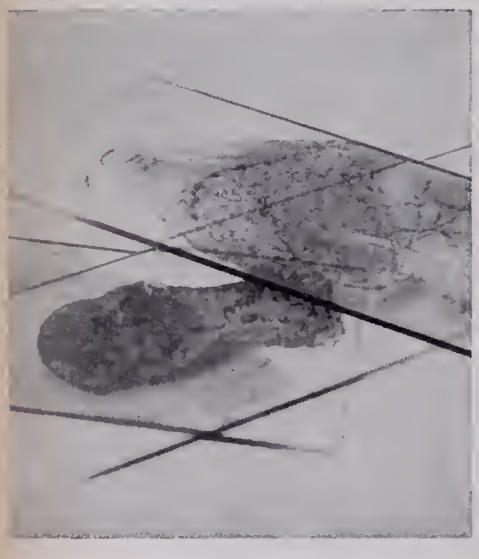
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



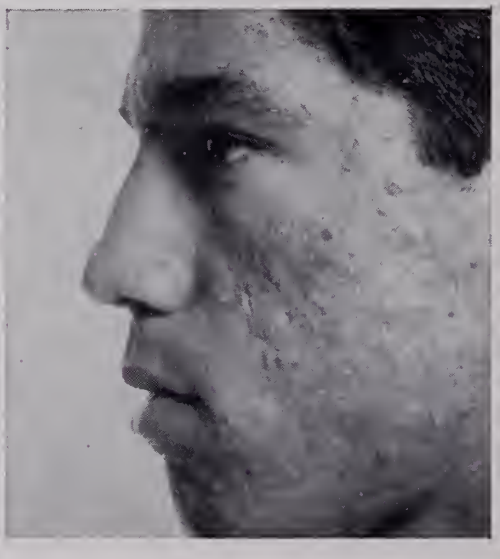
3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



PRESCRIBING INFORMATION. For complete inform tion consult Official Package Circular. *Indications:* fections of respiratory, gastrointestinal and genitourin tracts and akin and soft tissues due to tetracycline-sen tive organisms, in patients with increased susceptibil to monilial infections. *Contraindications:* The drug contraindicated in patients hypersensitive to its com nents. *Warnings:* Photodynamic reactions have been p duced by tetracyclines. Natural and artificial sunli should be avoided during therapy. Stop treatment if s discomfort occurs. With renal impairment, systemic ac mulation and hepatotoxicity may occur. In this situati lower doses should be used. Tooth staining and enar hypoplasia may be induced during tooth developm (last trimester of pregnancy, neonatal period and chi hood.) *Precautions:* Bacterial superinfections may occ Infants may develop increased intracranial pressure w bulging fontanels. In gonorrheal therapy, serologic te for syphilis should be conducted initially and mont for 3 months. *Adverse Reactions:* Glossitis, stomati nausea, diarrhea, flatulence, proctitis, vaginitis, dermati and allergic reactions may occur. *Usual Adult Dosage* capsule q.i.d. Continue for 10 days in Beta-hemolytic str tococcal infections. Administer one hour before or t hours after meals. *Supplied:* Capsules, bottles of 16 a 100. Each capsule contains tetracycline phosphate co plex equivalent to 250 mg. tetracycline HCl activity a 250,000 units of nystatin. For Oral Suspension, 125 m tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottl

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Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units



Now Is The Time

BOTH parties have selected their nominees for the Primary to be held on May 23, 1967. If we are to work effectively with the legislators to the next General Assembly, we must, during the next few weeks, acquaint ourselves as best we can with the candidates of our party in the Primary. It is only by so doing that we may exert any influence on the selection of intelligent and conscientious legislators for the next Assembly.

Physicians are the principal guardians of health care and health legislation in our state. Two years ago 110 bills were presented to our Legislature that had some bearing, either directly or remotely, on health matters. We can scarcely be expected to inform ourselves in minute detail with regard to all health legislation that is offered, but we do have a state legislative committee which tries to be alert and to keep the membership of the society informed in advance of its presentation. Most of the larger county societies also have legislative committees trying to perform a similar function. During the past few years we have learned a great deal, and it is to be hoped that we will enter into the affairs of the 1968 Legislature better informed for more intelligent activity than we have exhibited before.

The many physicians who have visited the legislature during the last few sessions and have attempted to exert some influence favorable to the proper medical measures have learned some fundamentals of procedure. The record indicates that we have fared well with health legislation in general, but we have had some narrow squeaks. We have wished that we had known our law makers better. We have regretted not to have informed ourselves of their views more completely before we met and talked with them about some specific measure. We have been embarrassed to recall that we had given our elected senator or representative no thought, no support, and no financial contribution during his campaign for election, and thereby have been handicapped in our efforts to present our viewpoint.

Several years ago we adopted the keyman system of dealing with our legislators. We have tried to choose one influential physician in each county or district and encourage him to make close acquaintance and good rapport with the legislator. As well as this system has worked it is impossible to get 100% effectiveness in this manner. We would be far more versatile if every physician considered himself the keyman to the legislator whom he knows or for whom he is the personal or family physician. Individual and long standing acquaintance and friendship can be far more effective than that which is so obviously cultivated for a specific professional or political purpose.

It would be well if we could begin now to acquaint ourselves with the background, the record, and political philosophy of our candidates in the Primary. If he turns out to be man of integrity and reliability and one who may be expected to be sympathetic toward our viewpoints on better health and civic legislation, it would be well for us to improve our acquaintance with him, to pay him a personal call if possible, to express our interest in his political ambitions, and to make some monetary contribution to his campaign. These are the tokens of friendship and interest which may stand us in the best stead when we may approach him for support during the legislative session of 1968.

Should every member of the Kentucky Medical Association consider himself the keyman to the elected or prospective legislator whom he knows, and to cultivate his friendship and goodwill, our chances for favorable health legislation would be remarkably improved.

SAM A. OVERSTREET, M.D.

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

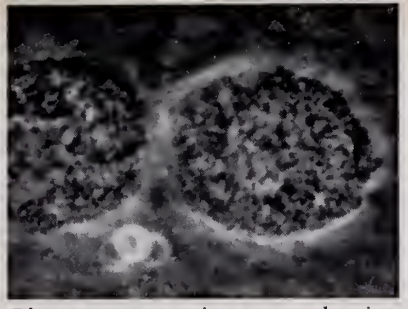


Visual evidence of how corticosteroids influence the inflammatory reaction

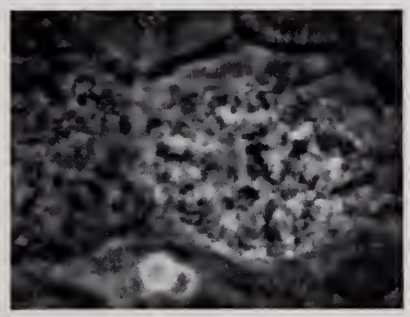
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



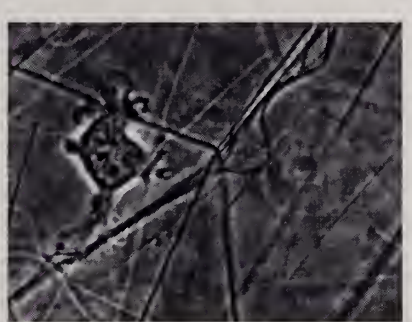
Phase-contrast microscopy showing mast cell before injury.



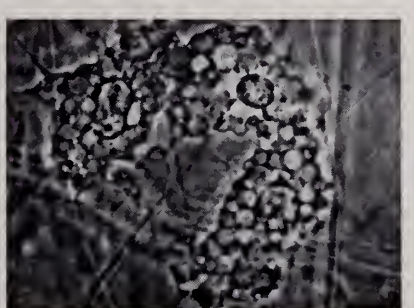
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid —Synalar (fluocinolone acetonide)— the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



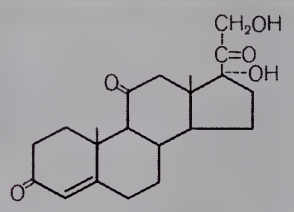
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

*A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

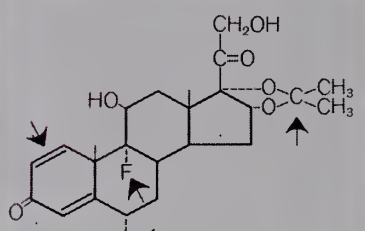
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

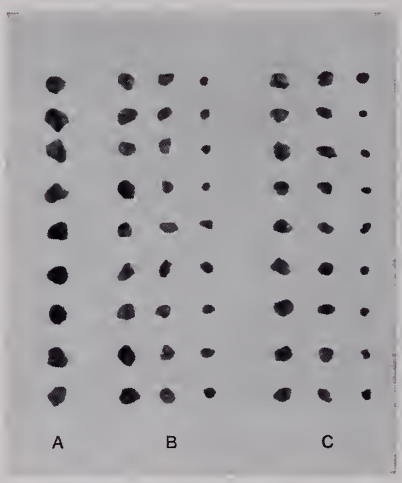


Fluocinolone Acetonide (Synalar)

- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Bornan, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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Why Wait?



*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

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ORGANIZATION SECTION

KMA Interim Meeting April 19-20 Promises Good Attendance

The 17th Annual KMA Interim Meeting, April 19-20 at Ken-Bar Inn in Gilbertsville, promises to be well attended, according to advance registration reports. The keynote speaker at the Wednesday evening dinner which opens the meeting will be Charles B. Shuman, president of the American Farm Bureau Federation, who will discuss the free enterprise system in a talk entitled "We Are Winning."

Paul I. Hoagland, M.D., Pasadena, California, the first of four well known speakers scheduled for Thursday's session, will give a talk entitled "Not in Mediocrity, But in Leadership." Doctor Hoagland is president of the National Association of Blue Shield Plans. William J. Lewis, Jr., M.D., Dayton, Ohio, president of the Montgomery County (Ohio) Medical Society, will speak on "Working To Win."

Joseph F. Volker, D.D.S., Ph.D., Birmingham, Alabama, director of the University of Alabama Medical Center, will discuss problems of medical manpower in a talk entitled "The Impact of Federal Legislation on Medical Practice, Education, and Research." F. J. L. Blasingame, M.D., Chicago, executive vice president of the AMA, will speak on "A Profession United" at the luncheon session closing the meeting.

At the time of the Interim Meeting there will also be a New Member Orientation Program April 19 and a meeting of the KMA Board of Trustees.

KMA Members Urged To Complete Survey Booklet Promptly

If you have not completed your KMA-Blue Shield Confidential Survey booklet which was mailed to you on March 22, you are urged to do so immediately by the KMA Advisory Committee for Fee Survey, Roy H. Moore, Jr., M.D., Louisville, chairman, said.

This confidential survey was authorized by the 1966 KMA House of Delegates when it passed Resolution "A" in amended form. The purpose of this study, as provided by the resolution, is to develop ranges of fees and other data which will assist the KMA in negotiating contracts for Federal Programs using the "usual and customary" concept.

The primary purpose, of course, is to provide information which will enable the Health Department to predict costs under the "usual and customary" concept in connection with the implementation of Medical Welfare Programs under Titles XVIII and XIX of PL89-97. Other programs include the providing of services for dependents of active members of the Armed Forces and veterans hometown medical care.

In supporting Doctor Moore in his request for prompt action on the part of each KMA member, the KMA President, Robert E. Pennington, M.D., London, said, "It is in the best interest of all concerned that each member complete the questionnaire and return it, as the Association is faced with early deadlines that it must meet."

Dr. Chumley, Scientific Editor of KMA Journal, Dies at 56

Jack L. Chumley, M.D., Louisville, scientific editor of the Journal of the Kentucky Medical Association since 1952, and past president of the Louisville and Jefferson County Heart Association, died March 10 at Norton Memorial Infirmary. He was 56.



Doctor Chumley

A specialist in internal medicine since 1945, Doctor Chumley was associate director of the Waverly Hills Clinic and a clinical associate at the University of Louisville School of Medicine from which he graduated in 1940. He was a member of the Louisville Society of Internists, Alpha Omega Alpha Honorary Medical Society, and Phi Chi Medical Fraternity.

Doctor Chumley was born in Houston, Texas, and served as a neuro-psychiatrist during World War II. He was editor of the Jefferson County Bulletin in 1961.

Praising Doctor Chumley's work on the KMA Journal, Walter S. Coe, M.D., Journal editor, said, "Jack Chumley did an excellent job for KMA as scientific editor of the Journal. Those of us who had the opportunity to know him and work with him will never forget him. His sharp and witty personality was always evident in his editorial work and in his writing. He had uncommon talents. We will miss him."

Thomas F. Plaut, M.D., Whitesburg pediatrician, has returned to New York after being associated with the Daniel Boone Clinic for the past two and one-half years. Doctor Plaut graduated from Columbia University in 1959. He has returned to New York to direct a major medical services project in the city's Bronx burrough.

12th Trustee District Meeting To Be May 3 in Somerset

An address by the KMA President and two scientific presentations will be featured at the 1967 Annual Meeting of the 12th KMA Trustee District Wednesday, May 3, in Somerset.

The meeting will start with a scientific program in the late afternoon, according to Robert F. Long, M.D., Somerset, Trustee for the 12th District. Wives of the physicians will also be invited to this session, which will be held in the Quality Court Motel.

"Diseases of the Large Bowel and Treatment" will be discussed by Coleman C. Johnson, M.D., Lexington. David H. Johnston, M.D., Lexington, will discuss "Diseases of the Small Bowel and Treatment."

Following the social hour and dinner at 6 p.m., Robert F. Pennington, M.D., KMA President, will talk on "What Do I Get for My KMA Dues?" A member of the KEMPAC Board will then briefly discuss its activities.

10th Trustee District Meeting To Be Held May 9

The annual meeting of the Tenth KMA Trustee District will be held in conjunction with the Fayette County Medical Society meeting at 7:30 p.m. Tuesday, May 9, at the Good Samaritan Hospital Auditorium, Lexington.

"What do I get for my dues?" will be the subject of an address by KMA President Robert E. Pennington, M.D., London, according to Douglas C. Scott, M.D., trustee for the Tenth KMA District.

Carl Cooper, M.D., Bedford, will also participate in the program with a brief discussion of the acts of the Kentucky Educational Medical Political Action Committee, Doctor Scott said.

Jessamine and Woodford Counties are included in the three-county Tenth District.

Dr. Kenyon, Oklahoma Pathologist To Speak at NGS Convention

Rex E. Kenyon, M.D., an Oklahoma City pathologist, will be the keynote speaker for the National Geriatrics Society's Fourteenth Annual Convention which will open at 9:30 a.m., Tuesday, May 9, at the Brown Hotel, Louisville. Doctor Kenyon, a graduate of the University of Oklahoma School of Medicine in 1951, is a past president of the Oklahoma County Medical Society and the Oklahoma State Medical Association.



Doctor Kenyon

"Coping with Behavioral Problems of the Senile" will be discussed at the May 11 session by H. Burl Mack, M.D., Pewee Valley. Robert S. Tillett, M.D., Louisville, will speak on "Care and Control of Diabetes," and Kenton D. Leatherman, M.D., Louisville, will discuss "Post-operative Patient Care."

Hoyt D. Gardner, M.D., Louisville, president of the Jefferson County Medical Society, will address the group at the Annual Grand Banquet at 7 p.m., Thursday, May 11, in the Crystal Ballroom. Other speakers scheduled during the three-day convention include Avil McKinney, director of professional and public relations for Blue Cross Blue Shield, Louisville, and John Pekarek, Wisconsin State Department of Health, May 9; Harry E. Voyles, M.D., Louisville, and Lew Bennett, Atlanta, May 10; and Hasty W. Riddle, executive director of the Kentucky Hospital Association, May 11.

KAGP 16th Annual Assembly Planned May 10-12

Colonel George E. Schafer, Vice Commander of the Aerospace Medical Division, Brooks AFB, Texas, will discuss aerospace medicine at the final session of the KAGP Sixteenth Annual Assembly Friday, May 12, according to Charles G. Bryant, M.D., Assembly chairman. The three-day meeting will open at 9 a.m., Wednesday, May 10, at the Convention Center, Louisville.



Colonel Schafer

The opening session will include discussions of eight papers on cancer. Speakers will be Hugh J. Davis, M.D., Johns Hopkins University, Hollon W. Farr, M.D., New York City, Jerome A. Urban, M.D., New York City, and Stuart S. Roberts, M.D., University of Louisville Medical Center. Columnist Art Buchwald will speak at the Wednesday luncheon for members' wives and guests at the Sheraton Hotel.

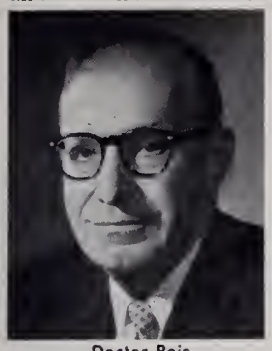
Papers on psychiatric problems will be given Thursday by Allen J. Enelow, M.D., Los Angeles, and Vann Spruiell, M.D., New Orleans. Thoracic medicine will also be discussed. J. Stuart Soeldner, M.D., Harvard Medical School, will present papers on the glycemias Friday. The annual banquet Friday evening at the Sheraton Hotel will feature entertainment by the Browning Family of Kansas City.

Robert M. Sirkle, M.D., Lexington, is president of KAGP. President-elect Thornton E. Bryan, Jr., M.D., Cadiz, will take office during the Assembly.

Robert H. Hyde, M.D., a general practitioner, has entered practice in Eddyville. He graduated from the University of Louisville School of Medicine in 1963 and completed his internship at St. Elizabeth Hospital in Dayton, Ohio, in 1964. Doctor Hyde has previously practiced in Winchester, Kentucky.

Dr. Reis To Address Ob-Gyn Soc. May 18-20 in Lexington

Ralph A. Reis, M.D., Chicago, will speak at the annual banquet during the spring meeting of the Kentucky Obstetrical and Gynecological Society May 18 to 20 at the Continental Inn, Lexington. Doctor Reis, who will also address the group at the May 19 morning session, is editor of Obstetrics and Gynecology and past president of the American College of Obstetricians and Gynecologists.



Doctor Reis

Three other out-of-state speakers will be highlighted on the program which includes a symposium on Office Gynecology, May 18, and a symposium on Pregnancy Complicated by Co-existing Maternal Disease, May 19. They are C. Donald Christian, M.D., Durham, North Carolina; Frank Peyton, M.D., Lafayette, Indiana; and Lee Stevenson, M.D., Detroit, according to John L. Duhring, M.D., Lexington, secretary-treasurer of the Society.

Francis Forde, M.D., Middlesboro, president, will conduct the session which will include 10 speakers. There will also be a meeting of the Kentucky State Maternal Mortality Committee at 10 a.m., May 20.

Dr. Witten Travels To England To Study Health Care Plan

Carroll L. Witten, M.D., president of the American Academy of General Practice, left Louisville on March 4, accompanied by his wife for a week's stay in London, England. Doctor Witten, a member of President Johnson's Health Insurance Benefits Advisory Council, was invited to England by Her Majesty's Government and was the guest of the Ministry of Health while he studied Britain's National Health Plan.

During his stay he was scheduled to visit the Greater London Health Council, which is in charge of all hospitals and medical care in London, and was to study the documents at the Ministry of Health to compare England's plan to Medicare and to Australia's National Health Scheme.

Doctor Witten, who attended the Third General Practitioners Convention in Australia last fall, has recently written a 41-page book on that country's nationalized medical care, which will be published in the near future.

Arthur E. Hess Promoted

Arthur E. Hess, who has been serving as Director of Health Insurance in the Social Security Administration, has been promoted to the position of Deputy Commissioner of Social Security. Hess is well known by Kentucky physicians.

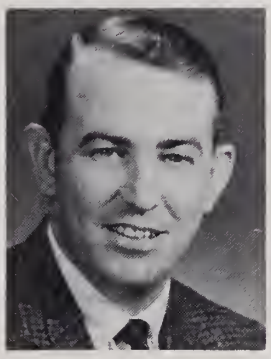
Ky. Surg. Soc. To Meet May 19

The Kentucky Surgical Society will hold its 18th Annual Session May 19 and 20 in Park City. A prominent Nashville surgeon will address the group, according to Blaine Lewis, M.D., Louisville, secretary of the Society.

Members may make reservations at Park Mammoth Resort, PO Box 27, Park City 42160 (502-458-9521), where the Society will meet.

Dr. Barton Receives Corbin Jaycees Award

Harold Barton, M.D., Corbin, received the Distinguished Citizen Award from the Corbin Jaycees at their annual Awards Night Banquet Saturday, February 4.



Doctor Barton

David Bobbitt, internal vice-president of the Corbin Jaycees, presented the award to Doctor Barton for his outstanding contribution to the community, both in his professional service and in his leadership in the re-activation of the Tri-County Country Club.

Doctor Barton is Chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee and a past KMA vice president.

Emergency Room Care Conference Scheduled June 10

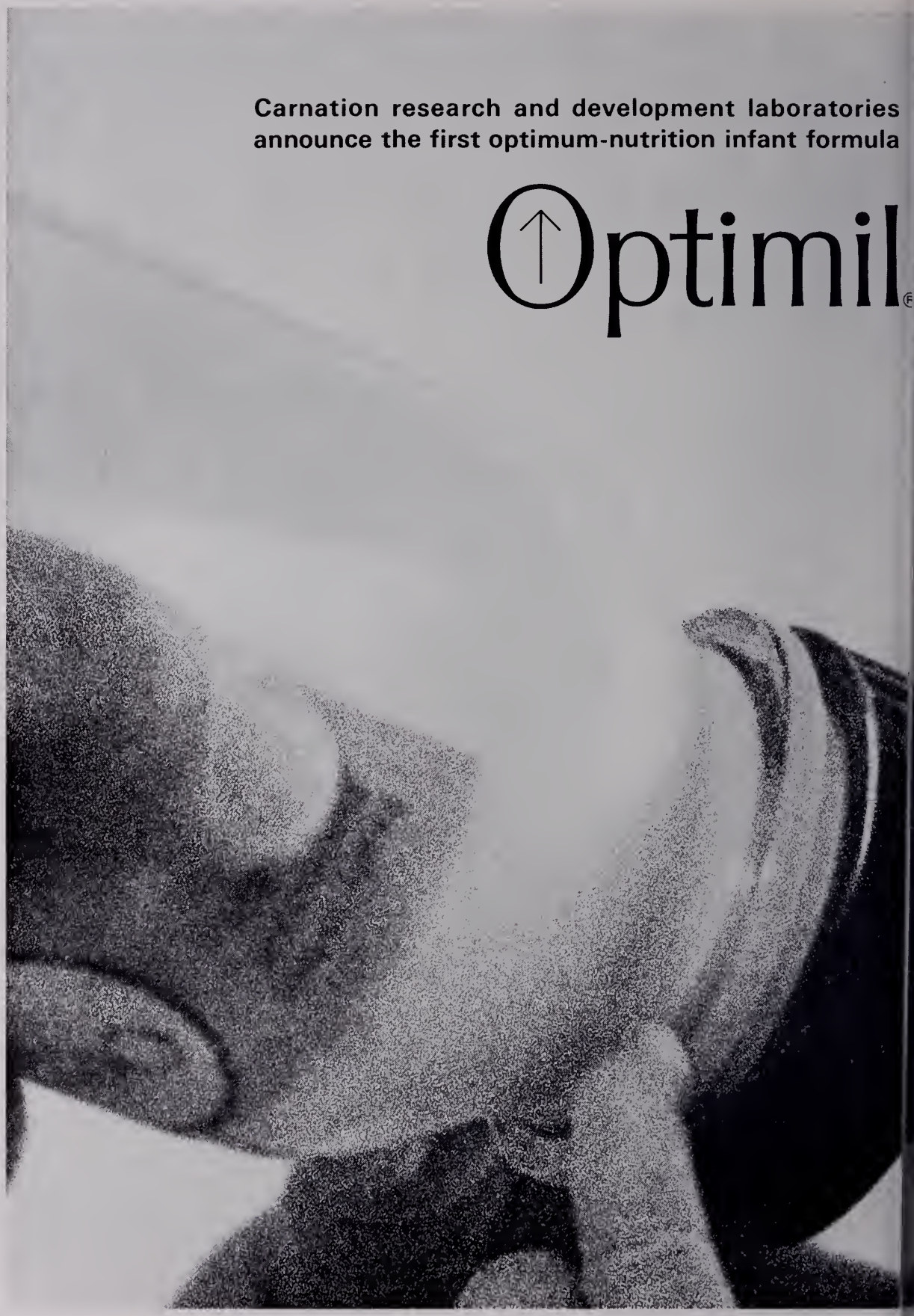
A conference on "The Hospital Emergency Room-1967: Problems and Proposals" for physicians, hospital administrators and nurses will be held from 9 a.m. to 3:30 p.m. Saturday, June 10, at Stouffer's Inn, Louisville. The Kentucky Medical Association, Kentucky Hospital Association and the Trauma Committee of the Kentucky Chapter, American College of Surgeons will co-sponsor the conference.

Speakers scheduled to appear on the program include Richard Manegold, M.D., Chicago, Director of the AMA Department of Hospitals and Medical Facilities; and Spencer T. Snedecor, M.D., Hackensack, New Jersey, Chairman of the American College of Surgeons, Subcommittee on Emergency Room Standards. Physicians, administrators and nurses will also discuss new approaches to emergency care recently put into operation in Kentucky.

Pre-registration, a requirement for conference participants, may be arranged through KMA Headquarters Office. The registration fee of $5.00 includes the luncheon and materials to be distributed at the conference.

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1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

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A skit by the KEMPAC Kuties will be the feature entertainment at the Saturday evening banquet of AMPAC's Annual Workshop, June 3 and 4, in Washington, D.C. The Kuties, from left to right, are: Mrs. Elmer Prewitt, Mrs. A. S. Holmes, Mrs. Harry Hamilton, Mrs. Harold Barton, Mrs. Dodson Pitman and Mrs. B. H. Wells. Mrs. Keith P. Smith (not shown) is the accompanist for the Kuties, all wives of physicians. All are from Corbin except Mrs. Pitman, from Williamsburg.

AMPAC To Hold Annual Workshop June 3-4 in Washington

The Fifth Annual AMPAC (American Medical Political Action Committee) Workshop will be held in Washington, D.C., June 3 and 4, according to National Chairman Blair J. Henningsgaard, M.D., Astoria, Oregon.

The "KEMPAC Kuties", who performed at the 1966 KEMPAC banquet, will be the featured performers Saturday evening, June 3.

This year's program at the Sheraton Park Hotel is expected to include previews of AMPAC's new educational materials, prominent speakers and campaign summaries from selected Congressional Districts.

First OVRMP Council (Heart, Cancer And Stroke) Meeting Feb. 22

The first meeting of the Advisory Council to the Ohio Valley Regional Medical Program (Heart, Cancer and Stroke) was held in Cincinnati Wednesday, February 22.

Medical schools included in this region are the University of Louisville, University of Kentucky, and the University of Cincinnati. William H. McBeath, M.D., Lexington, former Director of the Indigent Medical Care Program of the State Department of Health, is Director of the Council.

One of the main concerns that was reported at the first meeting of the Council was the best manner in which to use the $345,000 planning grant.

Of the thirty-six members of the Council, twenty-two are Kentuckians. These include nine physicians, one dentist, and twelve lay-people.

Kentucky physicians serving on the Council are:

Peter P. Bosomworth, M.D., Lexington
William M. Christopherson, M.D., Louisville
William W. Hall, M.D., Owensboro
James B. Holloway, Jr., M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
Donn L. Smith, M.D., Dean of the School of Medicine, University of Louisville
Russell E. Teague, M.D., Commissioner of Health, Frankfort
Loman C. Trover, M.D., Madisonville
William F. Willard, M.D., Vice President of the Medical Center, University of Kentucky, Lexington

The dentist serving is:

William C. Kranz, D.M.D., President, Kentucky Society of Oral Surgeons, Lexington

Symposium on Rheumatic Diseases

The Annual Post-Graduate Symposium on Rheumatic Diseases will begin at 8:30 a.m. Thursday, April 20, in the Rankin Amphitheater of the Louisville General Hospital. Theodore A. Potter, M.D., Boston University School of Medicine, will be guest speaker for the conference which will cover Osteoarthritis and Related Disorders.

There is no registration fee for the one-day symposium which is sponsored by the University of Louisville School of Medicine and The Kentucky Chapter of the Arthritis Foundation.

Resolutions Support KMA Program

Both the Kentucky Orthopaedic Society and the American Academy of Orthopaedic Surgeons have passed resolutions supporting the American Medical Association and the Kentucky Medical Association in their programs to suppress quackery.

The resolution, introduced by David B. Stevens, M.D., president of the Kentucky Orthopaedic Society, was passed by the national group at the January 19 meeting in San Francisco.

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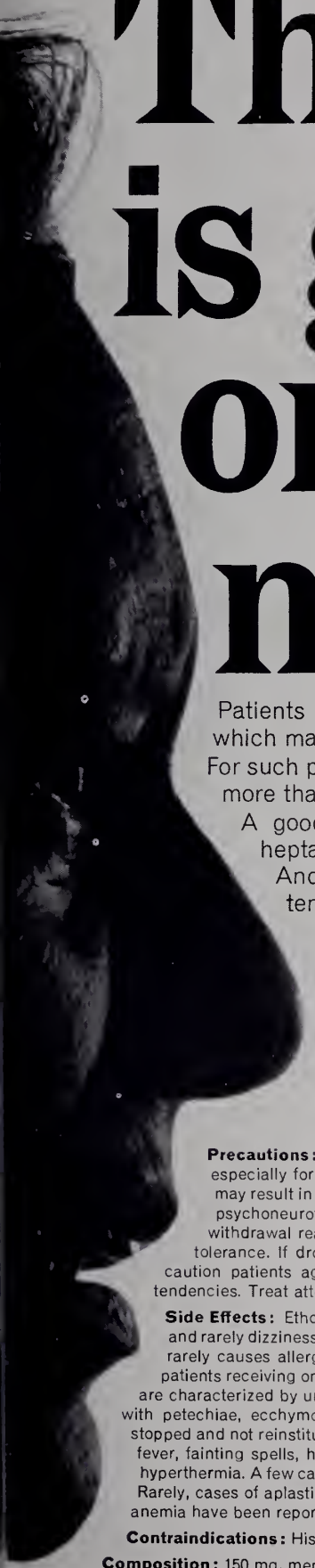
- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy.

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

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Henderson Co. Medical Society To Be 100 Years Old

The Henderson County Medical Society will celebrate its 100th anniversary May 27, 1967, according to a report from Walter L. O'Nan, M.D., past president and secretary of the organization. The first officers of the Society were J. H. Hodge, M.D., president, J. N. Powell, M.D., vice-president, and P. G. Valentine, secretary-treasurer.

John T. Berry, M.D., gave an address entitled "The Unity of the Medical Profession" at the first meeting, and at that time the Society recognized itself as auxiliary to the State Medical Association.

Members of the Society were instrumental in the formation of the McDowell Medical Society and the Kentucky State Board of Health. Four members of the Society served on the State Board including Pinckney Thompson, M.D., its first president. Five members have served as president of KMA.

Current officers of the Henderson County Medical Society are Molloy G. Veal II, M.D., president, and John Jenkins, M.D., secretary-treasurer.

Dr. Bruce Dies at 80

James W. Bruce, M.D., 80, a Louisville pediatrician for 45 years, died Thursday, March 2, in a local nursing home. Doctor Bruce, considered the dean of Louisville pediatricians when he retired in 1965, won wide recognition for his service to local hospitals and health services.

Doctor Bruce graduated from the University of Pennsylvania School of Medicine in 1912 and did postgraduate work in pediatrics at Columbia University and Harvard. He taught at the University of Louisville Medical School and served on the staffs of Children's Hospital, St. Joseph Infirmary, Norton Memorial Infirmary and Kentucky Baptist Hospital.

Internal Med. Mtg. Set May 24

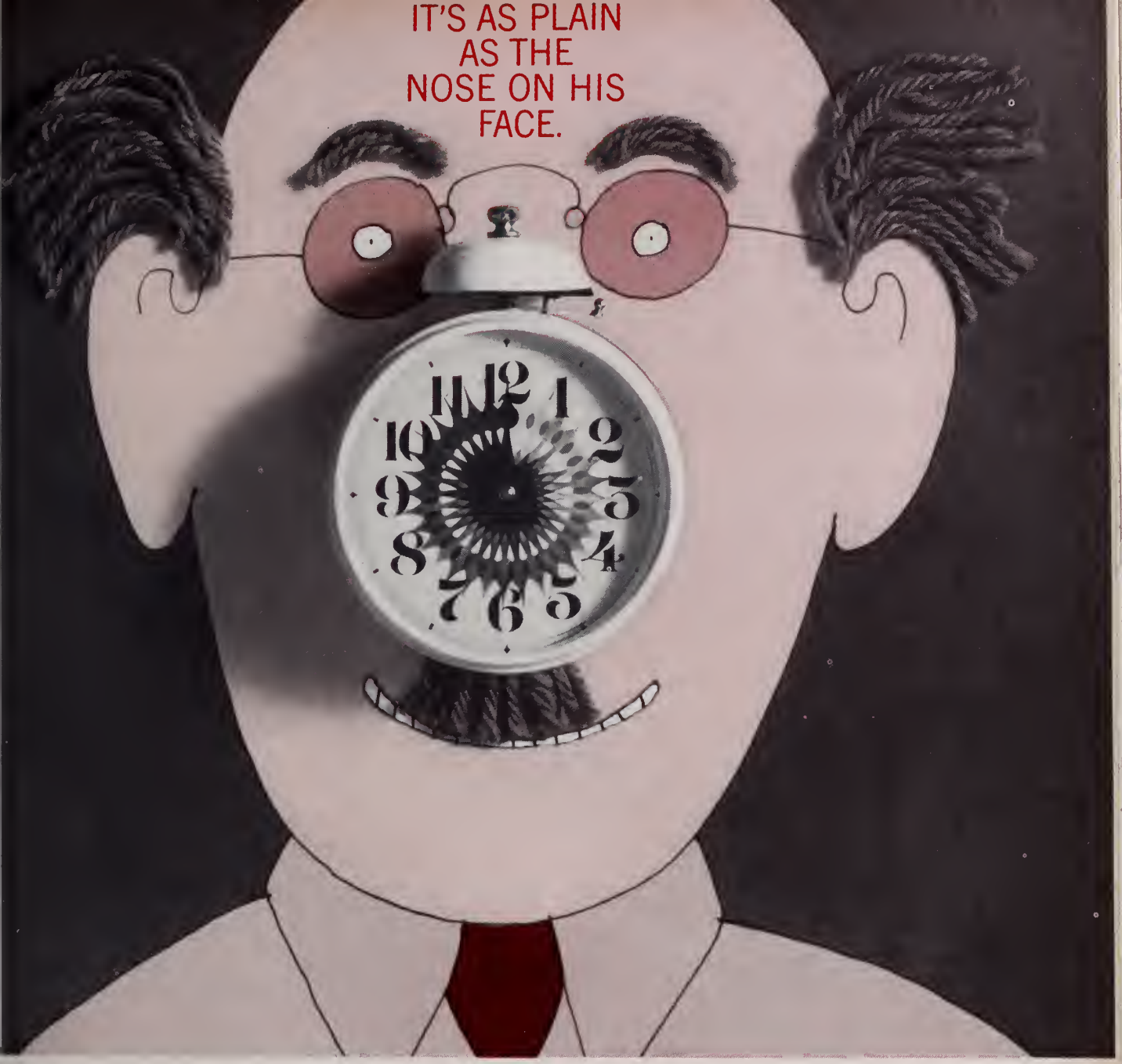
The Kentucky Society of Internal Medicine will hold its annual meeting at 6:30 p.m., Wednesday, May 24, at the Executive Inn, Louisville.

Peter J. Talso, M.D., Chicago, chairman of the Department of Medicine at Loyola University and trustee of the American Society of Internal Medicine, will be one of the principal speakers at the meeting, according to Karl C. Kelty, M.D., Lexington, president-elect of KSIM.

8th Trustee District Meeting

The Eighth KMA Trustee District Meeting, held March 2 at the Holiday Inn in Covington, was well attended, according to Leroy D. Hess, M.D., Florence trustee. KMA President Robert E. Pennington, M.D., London, and David B. Stevens, M.D., Lexington, spoke at the meeting.

Mrs. Raymond Jones, Louisville, president of the Woman's Auxiliary, and Mrs. Charles Kissinger, Henderson, president-elect, also attended the meeting which was held jointly with the Campbell-Kenton County Medical Society.



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ted side effects as few as the placebo,*
ned with decongestants phenyl-
rine and phenylpropanolamine—
dependable 10- to 12-hour form.

er, I. W., and Lowell, F. C.: New England
d. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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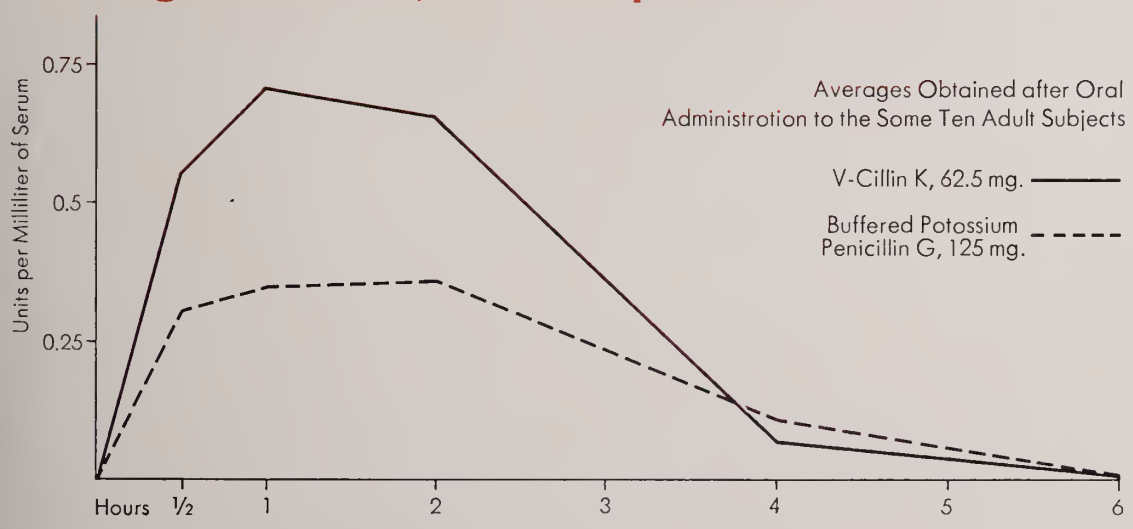
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because it combines a high degree of in-vitro activity...

Antibiatic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adopted from Klein, J. O., and Finland, M.: New England J. Med.,269 1019, 1963.

with high blood levels, even in the presence of food



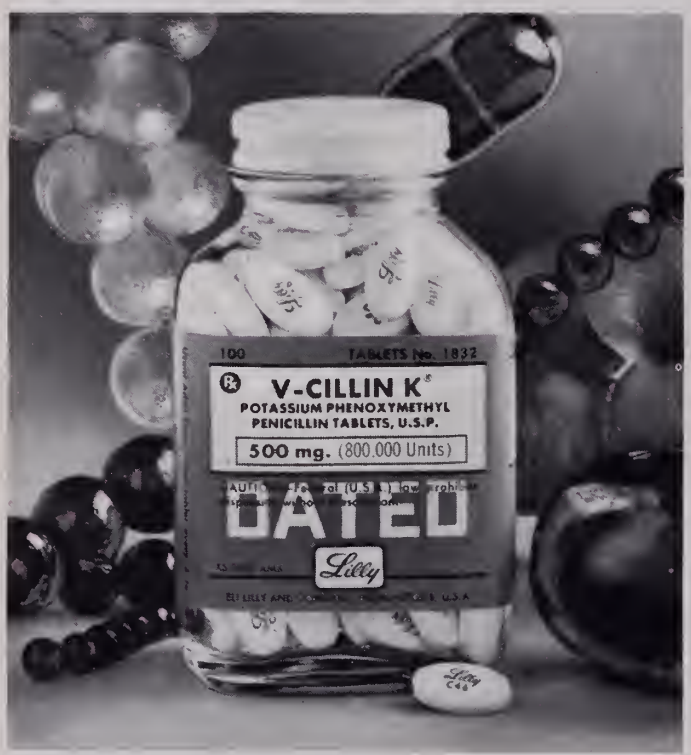
Adopted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

V-Cillin K® Lilly 700157

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penic hypersensitivity reactions occur, the drug should be discontinued

Adverse Reactions: Although serious allergic reactions are less common with administration of oral penicillin than with intram lar forms, skin rash, symptoms resembling those of serum sickne other manifestations of penicillin allergy may occur. When penici administered, measures for treating anaphylaxis should be re available. Those include epinephrine, oxygen, and pressor dru relief of immediate allergic manifestations as well as antihista and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the growth of antibiotic-resistant organisms; in such a case, antibiot ministration should be stopped and appropriate measures taken.

Administration and Dosage: For Tablets V-Cillin K and for V K, Pediatric, the usual dosage ranges from 125 mg. (200,000 three times a day to 500 mg. (800,000 units) every four hours. F fants, the daily dosage may be 50 mg. per Kg. of body weight d into three doses.

Beta-hemolytic streptococcus infections without associated remia may be treated with 200,000 to 400,000 units three times Therapy should be continued for a minimum of ten days to preve velopment of rheumatic fever and/or other serious complications age for routine streptococcus prophylaxis in patients with a hist rheumatic fever or congenital heart disease may be 200,000 unit or twice daily. When such patients undergo tonsillectomy, tooth tion, or other minor surgery, the prophylactic dose should be 5 units every six hours given two days prior to surgery and for tw postoperatively. If oral medication is not feasible on the day gery, parenteral therapy should be considered. Mild to mod severe pneumococcus pneumonia has been treated effective 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be every six to eight hours in conjunction with indicated surgical dures.

For gonorrhea in males, 500 mg. (800,000 units) every six ho three doses may be employed; in females, 500 mg. every four ho six doses are recommended. Patients with a suspected lesion of should have a dark-field examination before receiving penicil monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 u bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (8 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 uni 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Genetics Symposium Set May 19-20

A symposium on Genetics and Birth Defects for physicians and paramedical personnel will be held May 19-20 at the Sheraton Hotel, Louisville. Guest speakers for the symposium, which will be sponsored by the department of pediatrics, University of Louisville School of Medicine and The National Foundation, will include Josef Warkany, M.D., Leon Eisenberg, M.D., Catherine Palmer, M.D., and C. Charlton Mabry, M.D.

Chronic Hemodialysis Program Instituted at U of L

The University of Louisville School of Medicine began a chronic hemodialysis program within the department of internal medicine on July 1, 1966, for patients suffering from irreversible renal disease, according to L. B. Berman, M.D., project director. The U.S. Public Health Service awarded one of its 14 Public Health Service-sponsored centers for the program to the School of Medicine, and the School's renal service conducts the treatments in a ward made available by Louisville General Hospital.

Patients whose renal failure has reached the stage of interfering with normal life are potential candidates for the program. After a medical workup and placement in the suitable portion of the program, the patient is given a permanent prosthetic arteriovenous shunt in the arm, followed by two dialyses per week, each lasting 6 to 12 hours.

The center welcomes inquiries and visits from interested physicians who may call Ward 2-E, Louisville General Hospital, (502) 582-1621, Ext. 278.

Dr. Gardner Chosen AMPAC Officer

Hoyt D. Gardner, M.D., Louisville, currently serving as the president of the Jefferson County Medical Society, has been elected secretary and treasurer of the Board of Directors of the American Medical Political Action Committee.

Blair Henningsgaard, M.D., historian of the organization, was elected as the new AMPAC chairman. Doctor Henningsgaard has appeared before Kentucky physicans on several occasions.

Dr. Herrell to Edit Medical Digest

Wallace E. Herrell, M.D., former president of the staff of the Lexington Clinic, became editor and vice president of Medical Digest Publications on April 1.

Doctor Herrell, who has served as guest editor of The Journal of KMA and who held a position as a clinical professor in medicine at the University of Kentucky Medical Center, will reside in Northfield, Illinois.

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A NEW SERVICE FOR YOUR PATIENTS
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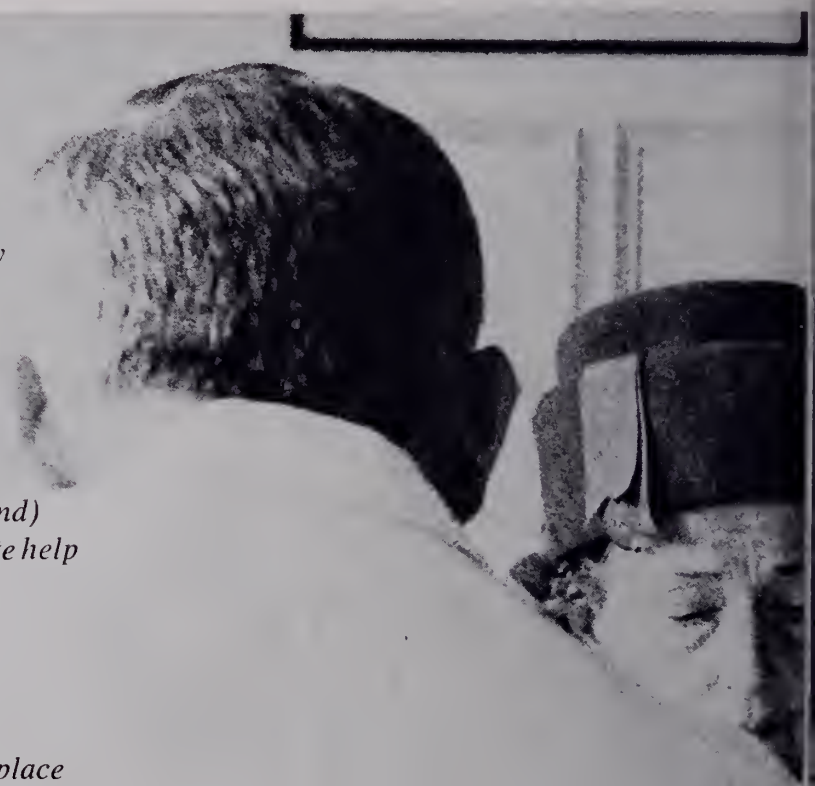
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There is a growing senescent body of people on their way to malignant inactivity, who sorely need your interest and direction to help them back to a more active and useful life. There are medicines too, designed to help. One such has proved useful in clinical practice.



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging ... This therapy resulted in improvement of 75 per cent of the patients ..."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied ... The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Designed for the "metabolically spent"

Nutritional reinforcement for those who can't – or won't – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation.* It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
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Contains 15% alcohol

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Each MEDIATRIC Tablet or Capsule contains:

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Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.



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6636

KMA Council and Committee Reports

Cancer Coordinating Committee

Condict Moore, M.D., Louisville, Chairman

KMA Headquarters Office **January 4, 1967**

Review and discussion of the Cervical Cancer Screening Program sponsored by the American Cancer Society, State Department of Health, and endorsed by the Kentucky Medical Association, was the primary concern of this committee at its first meeting of the year. All members and invited guests concluded that the program would progress best if it were concentrated for the present in a few counties whose medical societies signified in writing a desire for a real screening program.

Education through the use of speakers, films, film strips, and literature available from the American Cancer Society was stressed as a most important element of promotion. In addition, the committee recommended that successful promotions utilized elsewhere be used as a guide for use in areas where promotional methods had not been as successful.

Perinatal Mortality and Morbidity Study Committee

Guy G. Cunningham, M.D.
Ashland, Chairman, Presiding

KMA Headquarters Office **January 19, 1967**

The committee members reviewed current procedures of handling the high risk infant at birth and discussed methods or reducing infant mortality rates. A homogeneous form to be utilized in the follow-up procedure on premature and high risk infants is under study and development for hospital use when public health nurses make follow-up visits at the home.

In reducing infant mortality, the committee stressed the importance of using the team approach including the pediatrician, obstetrician, and public health nurses. For high risk and premature infants, visiting public health nurses may be especially helpful where the attending physician feels there is a need for such service. The establishment and use of nursery operating standards in Kentucky hospitals was also a part of the committee's consideration.

Committee on Medicine and Religion

R. Burke Casper, M.D.,
Louisville, Chairman, Presiding

KMA Headquarters Office **March 2, 1967**

A report by the chairman on the AMA Medicine and Religion Conference held in Chicago recently and a movie film, "The One Who Heals," dealing with the cooperative efforts of physicians and ministers were the basis for discussion of the committee's programs for the remainder of the year. Area and district reports were heard from committee members and from district Medicine and Religion Chairmen who met with the committee.

Following a broad discussion on the reports and the film, it was recommended to encourage the use of this film, edited tapes of physician interviews on medicine and religion made at the 1965 and 1966 KMA Annual Meetings, and available literature to assist all interested agencies in promoting programs on medicine and religion. The next meeting of the committee was scheduled for May 3, 1967, at the Headquarters Office.

Advisory Committee to the Medical School

Andrew M. Moore, M.D., Lexington, Chairman, Presiding

KMA Headquarters Office **January 12, 1967**

The committee members held a lengthy and productive meeting during their first session for this associational year and made a number of recommendations to the Board of Trustees through the Council on Medical Education and Hospitals.

Considered for appropriate disposition were such matters as training for audio-metric technicians, remuneration of house officers, scholarship funds, use of educational television, and training need for intensive coronary care units.

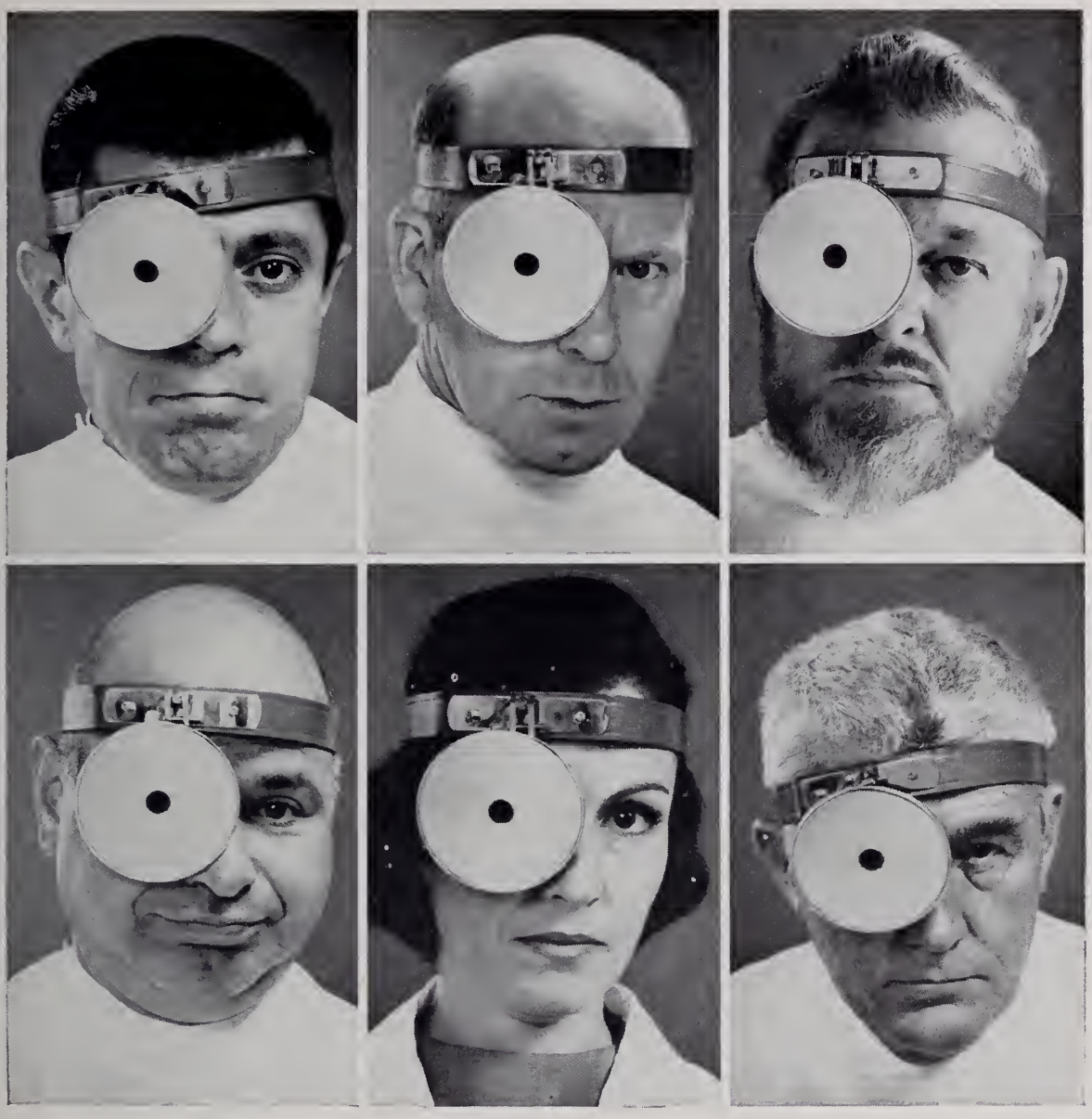
Reports relating to medical education discussed were "The Citizens Commission on Postgraduate Medical Education" (Millis Report), "Education for Family Practice" (AMA Report) and the Coggeshall Report. In addition, a progress report on PL 89-239 (Heart, Cancer, and Stroke Amendment of 1965) was received for information.

Dr. Andrews Honored By Jaycees

Billy F. Andrews, M.D., Louisville, a 34 year old pediatrician on the faculty of the University of Louisville School of Medicine, has been named one of three outstanding young men in Kentucky by the Kentucky Junior Chamber of Commerce.

The other two recipients of the Chamber's award are Tommy L. Preston, publisher-editor of the "Cynthiana Democrat", and James C. Vernon, owner-manager of radio station WYGO in Corbin.

General Practice, grossing $56,000 a year, available in Ohio. Included is modern, air-conditioned building, complete equipment, drugs, records. Excellent clientele in pleasant small community with hospital. Doctor leaving to take residency. Available July, 1967. Liberal Terms, $23,000. Write: Robert E. Goyne, M.D., Route 5, Upper Sandusky, Ohio. This practice can be taken for 1 to 2 years also as a Locum Tenens on a financially very rewarding basis.



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

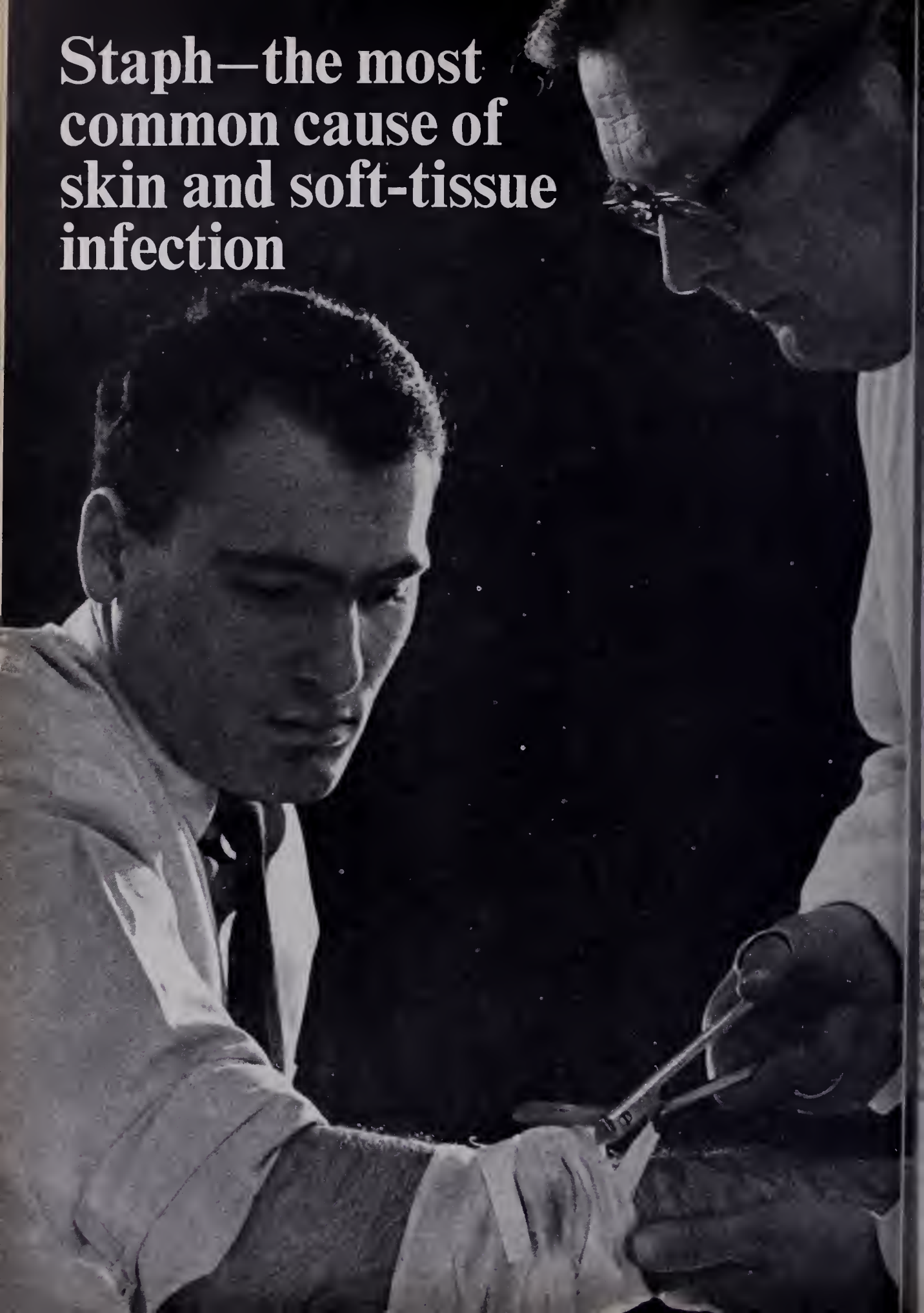
These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that a*ll* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.



Staph—the most common cause of skin and soft-tissue infection



reliably controlled with specific therapy



A suitable dosage form for every staph situation

Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.4* or *q.6h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.4* or *q.6h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY: 8:12.6**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Whenever you suspect staph PROSTAPHLIN®

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Disaster Medical Care Committee Outlines Emergency Bag

Every physician should have a bag especially for emergencies, according to members of the KMA Committee on Disaster Medical Care. At their December 29, 1966, meeting, the committee members noted the increased instances of accidents and agreed that every physician should be better prepared to handle emergencies on the spot.

Many medical kits have been developed for the physician who might find himself in an emergency situation. The KMA Disaster Medical Care Committee endorsed the contents of a bag as noted on this page, designed by Wayne P. Chesbro, M.D., of Berkeley, California, and estimated that the cost of these supplies would be about $80. The American Medical Association Committee on Disaster Medical Care has previously endorsed the concept of a second bag and its contents.

The purchase of a suitable bag was felt to be the best start by the committee members; they suggested that it should be sturdy, large enough to supply treatment material for three casualties, weigh 20 pounds or less when full, have contents readily accessible, and fit easily into an automobile trunk.

The purpose of the list is to suggest what is considered to be a full emergency bag with the hope that each physician might utilize it in making his own order from his supplier.

Suggested Items for Emergency Bag

fishing tackle type TOOL BOX .....
6 kling bandages 3" x 10 yds. .....
5 kling bandages 2" x 10 yds. .....
2 triangular bandages (arm sling, with two safety pins) .....
1 oz. cotton sterile absorbent .....
36 safety pins, medium size .....
4 oz. Alcohol isopropyl 70% .....
8 or more paper towels .....
6 prep tic isopropyl alcohol 70% swabs .....
6 Zephiran towelettes .....
3 adhesive tape ½ inch .....
1 roll adhesive tape 3" .....
1 roll Scotch Tape 1" .....
6 diag-nro cards 3" x 4" (pin or attach to pt. with Scotch tape)
1 skin marking pencil (red) e.g. eyebrow .....
½ pkg. cotton tipped applicators .....
4 oz. sterile lubricant jelly tube .....
1 rubber tub ng ¼" dia. by 12" length .....
1 eye patch with elastic band .....
6 ampules adrenalin 1:1000 .....
4 ampules vitamin K .010 .....
2 ampules caffeine sodium benzoate grs. vIIss each .....
10 c.c. vial Aramine Sol. 1%. .010 mgms per c.c. .....
10 c.c. vial Decadron Phosphate 1.m., I.v., use (.004/c.c.) ..
50 phenobarbital tabs grains ¼ .....
20 c.c. morphine sulphate vial gr ¼ per c.c. .....
30 c.c. demerol HCL vial, 0.050/c.c. .....
1 redisplint emergency pressure splint, full leg .....
1 redisplint emergency prssure splint, full arm .....
1 elastic bandage rediflex deluxe rubber 3", or plastic woven type
2 elastic bandages rediflex deluxe rubber 4", or plastic woven type
1 resuscitube, adult .....
1 resus tube, child .....
1 box bandaids, No. 100 to box .....
1 Xylocaine 2% 50 c.c. vial .....
1 Xylocaine 2% with adrenalin 1:100,000 50 c.c. vial .....
1 flashlight 2 cell D batteries (with holding ring & magnet holder) .....
1 Boy Scout knife .....
Dressing:
8 oversponges, 2 to pkg., 4x3" sterile .....
9 oversponges, 2 to pkg., 4x4" sterile .....
2 composite padding sterile 8 x 7½" .....
2 composite padding sterile 5 x 9" .....
2 D-unit drainage dressing sterile (lge.) .....
SUTURES:
6 4-0 ethilon with small curve atraloc needles, FS-2 sterile ....
6 2-0 ethilon with large curve atraloc needle, sterile .....
6 200 plain catgut, individual envelopes, sterile .....
INSTRUMENTS:
Knife, Bard Parker, #3 handle, #15 blade .....
1 Brown-Adson tissue forceps .....
5 mosquitoe hemostats (straight) .....
1 tissue scissors .....
1 bandage scissors (medium size) .....
4 examination gloves sterile, plastic .....
1 plastipak sterile disposable syringes with needles 5 c.c. 20 g 1"
6 plastipak sterile disposable syringes with needles 2½ c.c.-25 g ⅝" .....
1 B.D. Abelson curved crico-thyroidotomy cannula .....
1 scissors, medium fine, 5½" double point straight .....

Pulaski Co. Society Endorses Fluoridation for Somerset

The Pulaski County Medical Society has fully endorsed the action of the Somerset city council in requesting the local water company to install a fluoridation system for the city.

The Pulaski Medical Society carried a four column advertisement in the local daily newspaper, "The Commonwealth-Journal", listing the names of 23 members of the society supporting the action.

Vigorously opposing the water company in taking this step is a group known as "The Pulaski County Pure Water Committee" headed by a Somerset chiropractor, Christopher B. McNevin, according to pub-

Osteopaths Hear Dr. Maddox

Paul F. Maddox, M.D., Campton, was guest speaker at the 1967 Annual Meeting of American College of Osteopathic Obstetricians and Gynecologists February 13 through 15 at Las Vegas, Nevada. Doctor Maddox was scheduled to speak on "Practical Obstetrics in Appalachia" on the 13th and "Birth Control Practices in Appalachia" on the 15th.

AMA Seeks Retired Physicians

The AMA's Physicians' Placement Service hopes to develop a special information service for retired physicians interested in returning to practice, in accordance with a resolution adopted by the House of Delegates at the Las Vegas meeting in November, 1966.

The Placement Service plans to develop a roster of available opportunities for full or part-time physician employment and a list of interested physicians. KMA will transmit information on such opportunities in Kentucky and the names of physicians wishing to return to practice.

Locum Tenens Wanted For General Practice Louisville Area, No Obstetrics, Surgery or Hospital Pediatrics. July 15 through October 15. Guarantee $2000 per month or percentage—Call collect 1-502-935-1125.



"Livingston vertigo is my doom!"
Cried Stanley in his doctor's room.





Said the doc, "For your ills
I've got just the pills."



Said Stan,
"Antivert, I presume."

Antivert® tablets/syrup stops vertigo
(meclizine HCl, niacin)

Tablets: (meclizine HCl 12.5 mg. and niacin 50 mg.) Syrup: (each 5 cc. teaspoonful contains meclizine HCl 6.25 mg. and niacin 25 mg.)

Most widely prescribed anti-vertigo agent[1] Complete to moderate relief of symptoms in 9 out of 10 patients[2]

Antivert, the leading anti-vertigo product,[1] combines meclizine HCl, an outstanding drug for treatment of vestibular dysfunction, with niacin, a drug of choice for prompt vasodilation. Prescribe Antivert for your patients with vertigo, Meniere's syndrome and allied disorders.

Precautions and contraindications: Frequent, short-lived reactions include: cutaneous flushing, sensations of warmth, tingling and itching, burning of skin, increased gastrointestinal motility, and sebaceous gland activity. In explaining these reactions to the patient, it is suggested that they be regarded as a desirable physiological sign that the niacin is carrying out its intended function of vasodilation. Because of this vasodilation, severe hypotension and hemorrhage are obvious contraindications to Antivert therapy. Although the incidence of drowsiness and other atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. **Use in women of childbearing age:** A review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum. **Dosage:** One tablet or one to two teaspoonfuls (5-10 cc.) t.i.d. just before meals. Specific requirements for individual patients should be determined by the physician. **Supplied:** Tablets in bottles of 100 and 500. Syrup in pint bottles. RX only.

References: 1. Based on 1966 data from independent physicians' market survey organization. 2. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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geriatric ♀ supplement
helps keep them 'on the go'

Each capsule contains:

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Vitamin D (ergocalciferol, U.S.P.)	200 U.S.P. units
Vitamin B_1 (thiamine mononitrate, U.S.P.)	0.5 mg.
Vitamin B_2 (riboflavin, U.S.P.)	0.5 mg.
Vitamin B_6 (pyridoxine HCl, U.S.P.)	0.5 mg.
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Calcium pantothenate, U.S.P.	5 mg.
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Rutin	5 mg.
Cobalt (from cobalt sulfate)	0.033 mg.
Molybdenum (from sodium molybdate)	0.066 mg.
Copper (from copper sulfate)	0.33 mg.
Manganese (from manganese sulfate)	0.33 mg.
Magnesium (from magnesium sulfate)	2 mg.
Iodine (from potassium iodide)	0.05 mg.
Potassium (from potassium sulfate)	1.66 mg.
Zinc (from zinc sulfate)	0.4 mg.
(2) **Hematopoietic Factors**	
Iron (from ferrous sulfate)	3.40 mg.
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Methyltestosterone, N.F.	1.0 mg.
Ethinyl Estradiol, U.S.P.	0.006 mg.
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L-Glutamic acid	30 mg.

*Enzymatically active defatted material obtained from 250 mg. of whole fresh pancreas.

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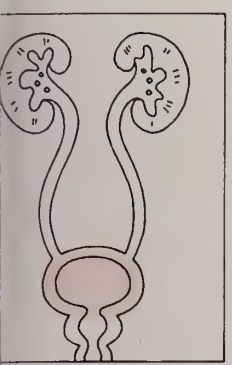
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The battle with bacteria: cystitis

Artist's conception of cystoscopic view of bladder showing congested blood vessels and edema around ureteral orifice.



onsider Gantanol (sulfamethoxazole)



For vigorous treatment of G.U. infections before the invaders become entrenched... Gantanol (sulfamethoxazole) offers a comprehensive spectrum of antibacterial effectiveness against most common gram-negative as well as gram-positive invaders. In addition, it provides satisfactory concentrations in blood and urine with ready diffusion into interial fluids for antibacterial activity at foci of bacterial asion.

h antibacterial activity against *E. coli* and other com- urinary pathogens... A review of 153 cases of acute J. infections reported in the literature shows that 90% responded to Gantanol (sulfamethoxazole), with over one-half of these patients showing excellent relief of symptoms.[1,2] Even in stubborn chronic G.U. infections, almost 60% of 450 patients improved on Gantanol (sulfamethoxazole), including many who had not responded to other antibacterials.[1-6]

Generally uncomplicated therapy enhances the favorable clinical results... Of the total 686 patients from the studies cited,[1-6] only three discontinued therapy because of side effects. Most of the side effects reported (approximately 3%) were mild and included nausea and/or vomiting, skin rash, dizziness, headache, gastritis, generalized uneasiness and itching.[1-6]

1. Peters, J. H.: *J. Urol.*, 87:747, 1962. 2. Draper, J. W., *et al.*: *South. M. J.*, 57:920, 1964. 3. Stewart, B. L.: *J. Urol.*, 87:491, 1962. 4. Hagstrom, R. S.: *Rocky Mountain M. J.*, 59:(2), 37, 1962. 5. Arnold, J. H.: *Clin. Med.*, 71:552, 1964. 6. Nelson, C. G.: *Colorado GP*, 3:(3), 2, 1961.

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ore prescribing, please consult complete product rmation, a summary of which follows:

traindicated in sulfonamide-sensitive patients, gnant females at term, premature infants, or newn infants during first three months of life.

nings: Use only after critical appraisal in patients n liver damage, renal damage, urinary obstruction lood dyscrasias. If toxic or hypersensitivity reacs or blood dyscrasias occur, discontinue therapy. In rmittent or prolonged therapy, blood counts and r and kidney function tests should be performed.

cautions: Observe usual sulfonamide therapy pretions, including maintenance of an adequate fluid ke. Use with caution in patients with histories of rgies and/or asthma. Patients with impaired renal ction should be followed closely since renal impairnt may cause excessive drug accumulation. Occanal failures may occur due to resistant microorgans. Not effective in virus or rickettsial infections.

erse Reactions: Headache, nausea, vomiting, urtia, diarrhea, hepatitis, pancreatitis, blood dyscra, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets b.i.d. or t.i.d. depending upon severity of infection. Children —1 tablet/20 lbs initially, followed by ½ tablet/20 lbs b.i.d.

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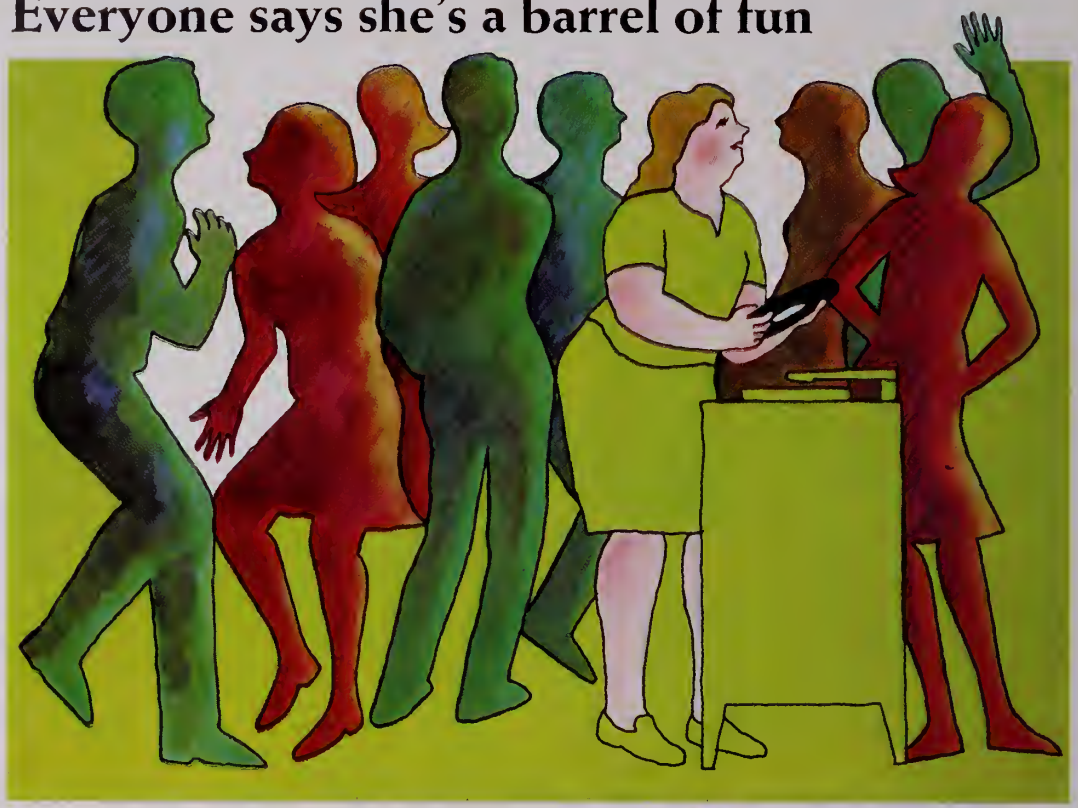
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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobomote.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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supplied in ¾, 1½, and 3-grain Pulvules



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arning: May be habit-forming.

ecautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



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Ky. Diabetes Assoc. Summer Camp

Physicians interested in recommending the Kentucky Diabetes Association's Second Annual Summer Camp for diabetic children, August 6-19 at Camp Daniel Boone, to their patients may obtain further information by writing to Diabetes Camp Headquarters, 204 Fincastle Building, Louisville, Kentucky, 40202.

Abdominal Pain Due to Filariasis

(Continued from page 380)

sionaries, travelers or immigrants. This is even more important in a disease such as filariasis for which there is good treatment in the early stages. In the advanced disease the grotesque physical enlargement and the associated emotional disturbances are not amenable to treatment.

References

1. Markell, E.: *Filarial Infections In A California Clinic.* Ann. Int. Med. *61:* 1065-1070, (Dec.) 1964.
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3. Harrison, E. and Thompson, J.: *Dirofilariasis of Human Lung.* Amer. Jour. Clin. Path. *43:* 224-234, (Mar.) 1965.
4. Beaver, P. and Orihel, T.: *Human Infection With Filariae of Animals In the United States.* Amer. Jour. of Trop. Med. and Hyg. *14:* 1010-1029, (Nov.) 1965.

Some Uncommon Drug Eruptions

(Continued from page 378)

phenolphthalein — the pigmented fixed drug eruption. If one is not certain, then the only practical possibility is to discontinue all drugs. Fortunately, some of the old favorite drugs, such as digitalis and coumadin, are still rare in the development of the orthodox type of generalized skin reactions, although coumadin may produce, rarely, a necrotizing vasculitis with gangrene.

The physician, then, must be aware of the possibility of anything possible happening as a reaction to drugs. He should know the common and usual reactions of the drugs which he uses daily and attempt to avoid drugs which often give reactions, if he can. The time honored and tried philosophy of the Doctrine of the Calculated Risk, used daily in the practice of medicine, will have to be continued since all daily living is a Calculated Risk procedure. It is in practice that the physician has the privilege and the opportunity to observe and also is duty bound to record the unusual or uncommon reactions. When he fulfills his duty by his critical observations and recording of these reactions he will teach others.

POST-GRADUATE SYMPOSIUM on RHEUMATIC DISEASES

Rankin Amphitheater **APRIL 20, 1967** Louisville General Hospital

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Glenn M. Clark, M.D. Memphis, Tennessee	*The Para-Osteoarthropathies and Allied Disorders*
Robert H. Freiberger, M.D. New York, New York	*Radiologic Features of Osteoarthritis*
Edward E. Gordon, M.D. Chicago, Illinois	*Physical Medicine and Rehabilitation in Osteoarthritis*
Theodore A. Potter, M.D. Boston, Massachusetts	*Orthopedic Approaches in Osteoarthritis*
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Refresher Courses Planned For Inactive Nurses

The Kentucky Nurses Association in cooperation with the Kentucky Department of Vocational Education is working to establish refresher courses for inactive nurses in an attempt to relieve the critical shortage of Kentucky hospital personnel. Interested nurses were asked to register in their counties during "Nurses Recognition Week in Kentucky" March 20-24.

Under a new directive from the U.S. Department of Labor priority attention is being given to the development of refresher courses for registered nurses under the Manpower Development and Training Act. Approval has been received from MDTA for activation of projects for 100 inactive nurses in Louisville, Lexington and Covington.

Nurses who have been out of practice for five years or more are eligible for a six-week refresher course under Manpower Development and Training Act auspices.

NEWS ITEMS

Roy L. Clemons, M.D., general practitioner, has recently started practice in Franklin. He graduated from the University of Louisville School of Medicine in 1963 and completed his internship at Tampa (Florida) General Hospital in 1964. Doctor Clemons was previously associated with the Riverview Hospital in Louisa, Kentucky.

According to a press report, William W. Dye, Paris, has closed his office where he has practiced for the past 15 years. He is moving to Naples, Fla.

New Item

Robert B. Cloar, M.D., general practitioner has started practice in Lexington. He graduated from the Tulane University Medical School in 1963 and completed his internship at the McLeod Infirmary, Florence, S.C., in 1964. He has previously practiced in Middlesboro, Kentucky and Dallas, Texas.

42 year old G.P. (A.A.G.P.) desires male associate, age 25-45. Southern California opening July 1, 1967, to associate with G.P. established 14 years, as replacement for well established associate of 11 years leaving for residency. Excellent income with salary guarantee and/or percentage, as desired, and eventual partnership possible. O.B. optional; excellent modern hospital facilities with teaching centers nearby. Modern, well equipped, air conditioned office, with six aides, located in Whittier, Calif. midway between nearby beach, mountain, and desert resorts, all with outstanding recreational facilities. Nearby metropolitan area offers cultural and educational opportunities.

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William H. Klompus, M.D., urologist, has started practice in Madisonville, in association with the Trover Clinic. He graduated from the New York Medical School in 1959, completed his internship and residency training at Harrisburg's Polyclinic in 1961 and completed residency training at the University of Louisville in 1966. Doctor Klompus served in the Air Force, as a captain, from 1961 to 1963, and has previously practiced medicine in Pennsylvania.

Joseph C. Stiles, M.D., Owensboro, was installed as a Fellow of The American Academy of Orthopaedic Surgeons at a recent meeting in San Francisco.

Robert A. Noel, M.D., general practitioner, has opened an office at 3612 Lexington Road, Louisville. Doctor Noel graduated from the University of Louisville in 1965 and completed his internship at St. Joseph Infirmary in 1966.

SPECIAL ARTICLE

(Continued from page 381)

The key to the organized chaos is the Lexington Fire Department which serves as coordinator for transmission of information, loading of casualties, and distribution to the various hospitals.

In addition to the usual means of ground transportation; 12 ambulances, 6 station-wagons, and 1 bus, 3 helicopters from Fort Knox, Kentucky cooperated in this exercise and air lifted 30 casualties to the University Medical Center where a helioport is available. This method of evacuation was found to be extremely efficient in removing casualties from remote areas not accessible to ground motor transportation.

Each of the hospitals has its own disaster director and he is notified by the hospital following which hospital calling teams contact the staff physicians who have pre-assigned responsibilities in the hospital. By the time the casualties have been sorted and started to move toward the hospitals, physicians have been assembled in the hospital so that they may perform triage of patients upon admission and then dispose of them to specific areas that have previously been designated.

While at times it seemed agonizingly slow to triage a patient, apply first aid, and transport him, it was with great relief that we found that in one and one-half hours all the injuries had been cleared from the disaster site, transported to the hospitals, and had been appropriately sorted and cared for in the hospitals, bringing to a close a successful disaster exercise.

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You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE 5-65—This 38 year old married negro gravida 9 para 7 was under the care of a private physician. She was delivered of a stillborn infant in January, 1964 by a midwife. Her last menstrual period began on August, 1964. She was seen initially in the sixth month of gestation on February 9, 1965. At the first visit she weighed 178 pounds; the blood pressure was 170/90, hemoglobin 89 per cent, urine negative, VDRL negative. She was seen again on May 9, 1965 when she had slight edema of her ankles and albuminuria. Oral diuretics reduced this. The blood pressure was 134/62, weight 186 pounds. She had a history of short previous labors.

The patient was admitted to the clinic at 12:05 P.M. on May 13, 1965 giving the history of having been in labor for 18 hours. She was having uterine contractions at ten minute intervals when admitted. The cervix was dilated to 4 centimeters on vaginal examination; the presentation was vertex with intact membranes. Following an enema, 1000 cc of 5 per cent dextrose in water with 1 cc Pitocin added was ordered intravenously and started at 40 drops per minute. This increased the contractions from every ten to every three minutes. At 1:30 P.M., the membranes ruptured during vaginal examination; the cervix was now 5 centimeters dilated. At 2:00 P.M. cervical dilation was 5 - 6 centimeters, and the contractions were occurring every two minutes. The patient delivered a living girl weighing 7 pounds 1 ounce in bed at 2:30 P.M. without anesthesia or laceration. The placenta was expressed at 2:45 P.M., and bleeding was described as "heavy." One cc Pitocin and 1 cc Ergotrate were given intramuscularly and uterine massage applied; the fundus proceeded to contract.

The postpartum course was uncomplicated till 3:30 P.M. when she became "shocky" and started to bleed freely. She was given 0.5 ml Driralfa (a methamphetamine) intramuscularly and 500 cc of dextrose in water intravenously followed by 500 cc of dextran. At 4:00 P.M., the blood pressure was 80/50. An abdominal binder was applied (the reason was not given), and the patient was described as doing well. The physician stated in his narrative that the family left after bringing the patient to the hospital. However when she again went into shock at 6:00 P.M., he decided to call an ambulance without the consent of the family to move the patient. She was given .5 ml Driralfa intramuscularly and the dextran was continued. The ambulance arrived at 6:55 P.M., but she expired en route to the hospital at 7:15 P.M. The cause of death was hemorrhage due to postpartum uterine atony. There was no autopsy.

This was classified as a direct obstetric death with preventable factors. The Committee felt that the patient was actually in labor when the Pitocin was started, and if needed certainly it should not have been given at 40 drops per minute. The Committee suggested that Pitocin should be used to stimulate labor only in a hospital when an emergency laparotomy could be performed immediately should an emergency arise as in this case. It was also pointed out that if the uterus is explored following delivery of the placenta, any defect that is present can be detected. The Committee thought the most likely cause of death was a ruptured uterus.

A Building Block approach to treating hypertension

ABBOTT

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

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Enduron eliminates sodium around the clock, yet is relatively sparing of potassium

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect — with little reduction in intensity during the first 12 hours, and decline thereafter only gradual.

Potassium loss, in contrast, reaches an early minor peak. Then it subsides rapidly. Moreover, doses larger than 5 mg. have little added effect on potassium. Thus doubling the dose from 5 to 10 mg. approximately doubles sodium excretion—yet increases potassium loss little or none.

Use Enduron once a day as an ideal starting therapy in mild hypertension. Use it, too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component compares favorably to reserpine, but with reduced side effects

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid. It is comparable to reserpine in its antihypertensive and tranquilizing activity. Yet it produces less tendency toward typical rauwolfia side effects such as drowsiness, lethargy, stuffy nose, depression, etc.

Patient acceptance has been excellent.

Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most needed: in the deserpidine. These scored tablets give a surprisingly flexible choice of doses (see below).

Use Enduronyl for your patients within the broad range of mild to moderate hypertension. Dosage is *once* a day: this means Enduronyl will generally cost patients less than equivalent drugs taken two or three times daily.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

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Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance, with little or no effect upon cardiac output.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied — including some unusually difficult cases. Eutonyl lowers diastolic in proportion to systolic, and in half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, many patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures—reduced chance of orthastatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

Indeed, fully 94.5% of all patients studied during clinical trials continued on therapy uninterrupted by side effects.

Most striking was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, with reduced likelihood of orthostatic effects. And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.





Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

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704075

ENDURON
METHYCLOTHIAZIDE

ENDURONYL
Each tablet contains Methyclothiazide 5 mg.
with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild hypertension. Also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Enduronyl is contraindicated in severe mental depression, active peptic ulcer, and ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small bowel lesions; if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical.

Precautions and Adverse Reactions: Use thiazides with caution in severe renal dysfunction. Caution is also necessary with impaired hepatic function or progressive liver disease. During intensive or prolonged thiazide therapy, watch chloride and potassium levels (especially the latter if patient is on digitalis). In surgical patients, thiazides may alter response to vasopressors and tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism are possible in certain newborn). Occasional thiazide side effects also include blood dyscrasias; elevations of BUN, serum uric acid, or blood sugar; electrolyte imbalance, g.i. disturbances, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, pancreatitis, and gout.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfias may increase hypotensive effects of surgery or anesthesia, and are best discontinued two weeks prior. They also lower the convulsive threshold in epilepsy. Other possible rauwolfia side effects include drowsiness, nasal stuffiness, nausea, weight gain, and diarrhea. Less frequent complications of deserpidine therapy are aggravation of peptic ulcer, epistaxis, and skin eruption. Alcohol, barbiturates or narcotics may potentiate action of deserpidine.

EUTONYL®
PARGYLINE HYDROCHLORIDE

EUTRON™
Each tablet contains Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

Contraindications: Pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained, not recommended for use in patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. Interval of two weeks should separate therapy and use of these agents.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When necessary to administer alcohol, narcotics (meperidine should be avoided), antihistamines, anesthetics, barbiturates, chloral hydrate and other hypnotics, sedatives, tranquilizers, or caffeine, these can be used cautiously at a dosage of ¼ to 1/5 the usual amount. Adjust dose of anesthetic agents to response of patient. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions; if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver dysfunction or progressive liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

During intensive or prolonged methyclothiazide therapy, watch chloride and potassium levels (especially latter if patient is on digitalis). Methyclothiazide also may reduce arterial response to pressor amines. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism are possible in certain newborns). Thiazide drugs may increase responsiveness to tubocurarine.

Side Effects: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Thiazide side effects also include blood dyscrasias, elevation of BUN, serum uric acid, or blood sugar, electrolyte imbalance, g.i. disturbances, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, pancreatitis, and gout. Nocturia has been observed with the combination.

704075

ABBOTT



THE INSURANCE PAGE



AMA Policies on Payment for Professional Services

A REVAMPED current policy statement regarding payment for professional medical services was adopted by the AMA House of Delegates at the recent Clinical Convention in Las Vegas. The statement provides excellent background information and contains a clear expression of the major policies of the AMA on the subject as they now exist. In adopting these policy points, the house indicated it hoped they would serve as clear guidelines for physicians in responding to the proposals of other agencies.

1. It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.

2. It is proper for third party agencies to make payment of medical fees in behalf of patients, with recognition of the fact that the service of the physician has been to the patient and the liability for payment rests primarily with the patient or his family.

3. It is proper for a physician to work cooperatively with other physicians in a team approach to the provision of medical service, with recognition of the fact that each cooperating physician is entitled to compensation according to the value of his services, and that the charges attributable to each physician's service shall be made clearly known to the patient.

4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.

5. A physician should not enter into a contract or agreement with a hosital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the Principles of Medical Ethics and established policy of the American Medical Association.

6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit, and disburse as they may agree.

7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.

8. The physician is the sole arbiter as to the ways in which he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

WILLIAM W. HALL, M.D.



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

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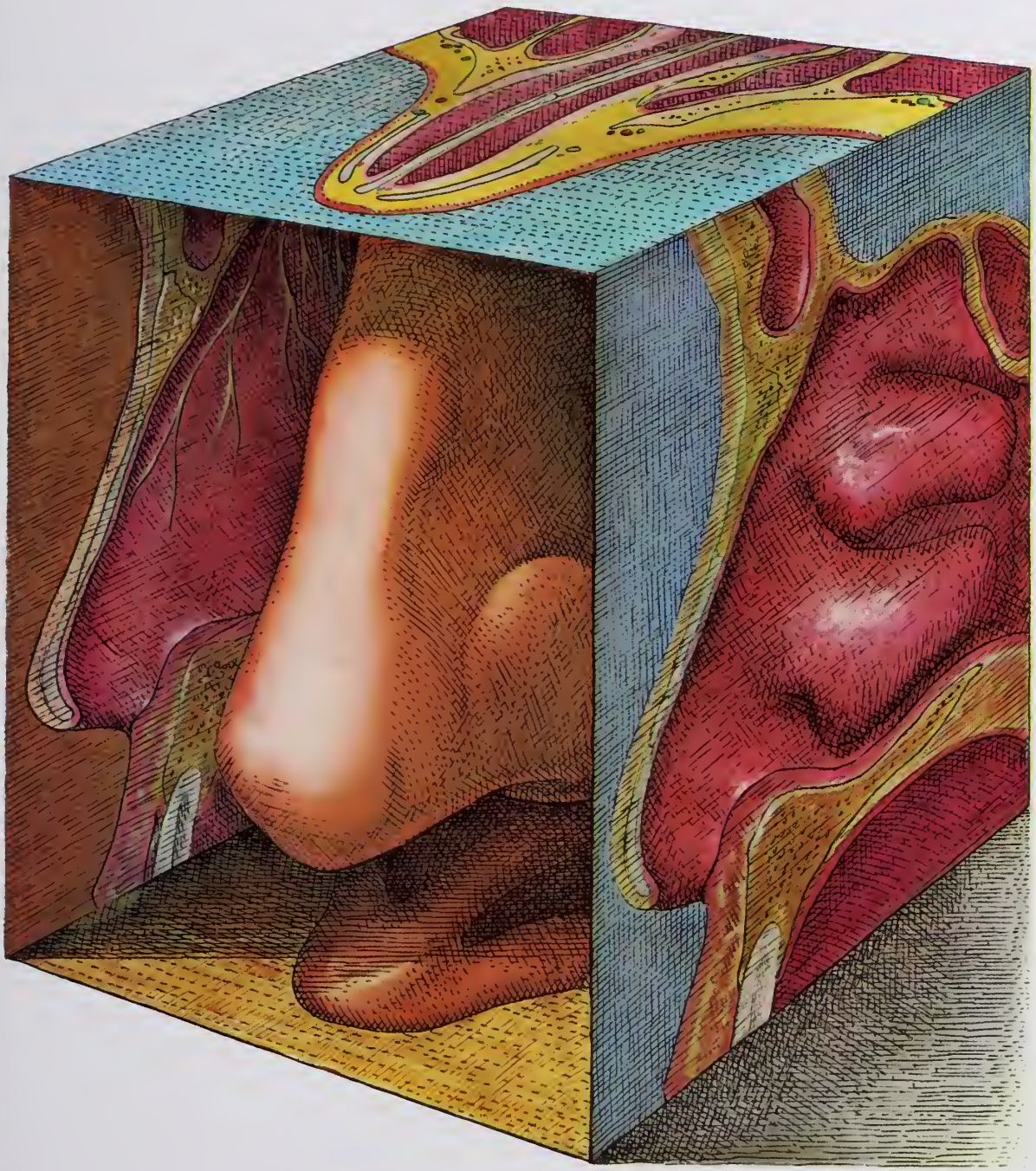
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spring 1967

DORSEY Season

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this issue: the ubiquitous world of summer allergies



the ubiquitous world of summer allergies

Donald L. Unger, M.D. • Clinical Assistant Professor, Department of Medicine (Allergy), Stritch School of Medicine (Loyola).

In the Spring a young man's fancy lightly turns to thoughts of—allergies. This is at least true of the 10% of the population who have hay fever and the 4% who have asthma.[1] The snow melts, the trees blossom and the noses run. Patients who were fine all winter may not be enthralled by the sight of the first robin or the blossoming of a crocus, for their appearances may precede the "sneezin' season."

Allergies in general can be divided into winter allergies and summer allergies. In the winter the main problems are inside the house: e.g. dogs, cats, dust and feathers. Houses in the northern half of the country become so dry that it becomes essential to add humidity to the home; this is a far cry from the damp summer months with the moldy basements and need for dehumidifiers.

Early in April trees begin to pollinate, with each tree having about a two week period of pollination. A particular patient may be sensitive to only one tree and thus have his hay fever for such a short time that he thinks he has a cold.[2] The entire tree season starts about April 1 and ends about Memorial Day, although all hay fever seasons are blurred and prolonged in the southern part of the country. Tree pollen is usually very heavy and a person may well have most of his exposure from those trees immediately surrounding his home.

Grasses pollinate from about May 15 until July 4, and cause "rose fever." Grass pollens are somewhat lighter and more buoyant than tree pollens, and are much more ubiquitous. While there are several varieties of grasses in the United States, they are so closely related antigenically that a person sensitive to one is generally sensitive to them all.[3] Thus, while the tree season is really several small seasons intertwined, the grass season will usually result in symptoms for a more prolonged period. Obviously, a grass-sensitive patient will have trouble only when grass is pollinating—he will have to think of another excuse not to mow the lawn after July 4.

Ragweed is the "Big Daddy" of them all in the eastern two-thirds of the country. Pollination is generally from mid-August until the end of September, with the predicted lower counts and longer seasons



in the southern part of the country. Ragweed is a very light pollen which may be windborne for hundreds of miles. An interesting study was made in New York City, in which 90% or more of the ragweed plants were destroyed in three of the five boroughs; pollen counts done during the season were virtually identical in all five.[4]

Ragweed is, of course, the most common cause of hay fever and is associated with an incredible loss of man hours from work each year. Many is the patient who travels to areas where the pollen count is low, just to avoid having symptoms. There is no ragweed anywhere in the world except the United States and portions of Canada and Mexico.

While molds are present through the year, the most important ones predominate from April until November. An old wives' tale has ragweed ending with the first frost, when actually it ends a good month earlier. It is Alternaria—the kingpin of the molds—that meets a sudden demise with the first frost. Alternaria-sensitive patients are in their glory when there is snow on the ground, and might be ideally suited to man the radar stations in Alaska. In September and October, Alternaria counts are at their highest, perhaps associated with the burning of leaves. Other molds such as Hormodendrum and Helminthosporium are associated with the warmer weather, as opposed to Penicillium and Aspergillus which are household molds.

Summer also means the return of our much maligned associates—bugs. Insects cause allergic symptoms by two methods: the bite or sting of the Hymenoptera group, and the inhalation of particles of the bodies of various insects. Wasp stings are the oldest known form of allergy, as they caused the death of one of the pharaohs in ancient Egypt.[5] Bees, wasps and hornets account for many deaths in this country, and those sensitive to them should carry special treatment kits at all times; a few minutes delay in the administration of epinephrine to such a patient, might be the difference between life and death. Inhalation of particles of insects may cause sneezing and wheezing in a susceptible individual.[6] Both of these forms of insect allergy may be benefitted by hyposensitization.

The insect recognizes no professional bounds. He is as apt to bite the physician as the patient. So this season, beware of bugs. And beware, too, of poison ivy. That pleasant stroll through the woods and underbrush with the Boy Scouts might turn into a

(Concluded on following page)

to relieve summer allergies

Triaminic®

Each timed-release tablet contains phenylpropanolamine hydrochloride 50 mg., pheniramine maleate 25 mg. and pyrilamine maleate 25 mg.

It's a comforting thing to know

For product information see following page

(Advertisement)

nightmare for the botanically uninitiated in the causes of rhus dermatitis (poison ivy, poison oak and poison sumac). Although you may have been careful, your dog may not have noted that it wasn't clover he jumped through, but poison ivy. His return to your side may give you the rhus dermatitis that you so carefully avoided. That heavenly campfire may be emitting particles of rhus oil to produce an airborne contact dermatitis of the exposed areas of the body.

Another fascinating, but rather infrequent type of summer allergy is physical allergy. Some people sneeze on exposure to sunlight, while others break out in rashes, usually on the exposed parts of the body. These rashes may well follow the administration of various photosensitizing drugs, e.g. demethylchlortetracycline.[7] Another form of physical allergy and one that may be lethal in the summer, is cold allergy. Yes, I mean cold allergy, not heat allergy. The cool dip on a hot day with its consequent sudden chilling of the body, may be the coup de grace for a cold sensitive patient.[8] It is customary to write "heart attack" on the death certificate, even though the victim may have been an 18-year-old boy who looks like a Greek god.

Lest the reader be depressed by this saga of afflictions associated with the warmer months, perhaps he should remember that it is also a time for swimming, baseball, lying in the sun and taking that long-planned vacation. So let's all join in a chorus of "In the Good Old Summertime," as we sneeze, wheeze and scratch. Be careful of your suntan lotion, however; it may cause you a contact dermatitis.

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How can he be a sport with a runny nose?



For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
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Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort

Triaminic® relieves summer allergies

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

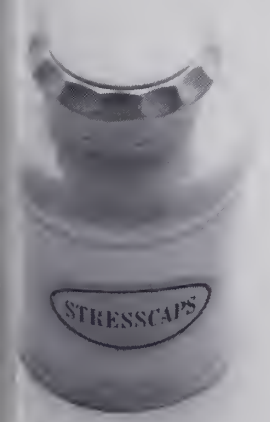
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OF THE KENTUCKY MEDICAL ASSOCIATION



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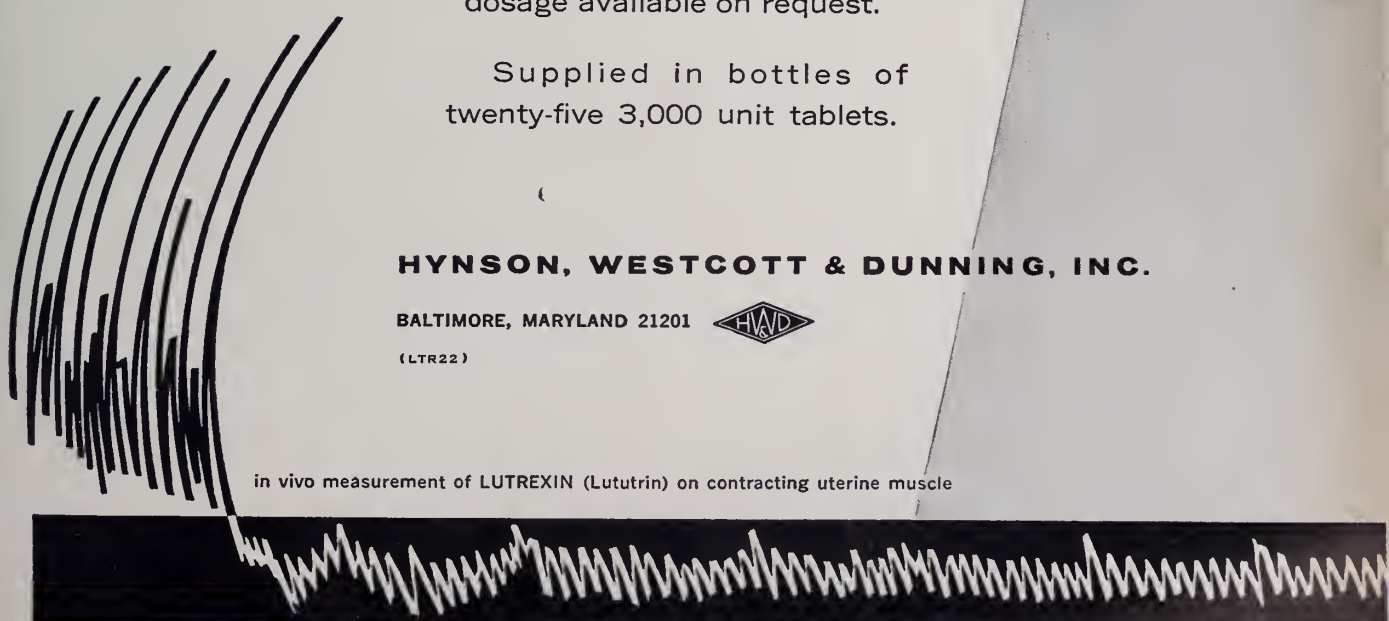
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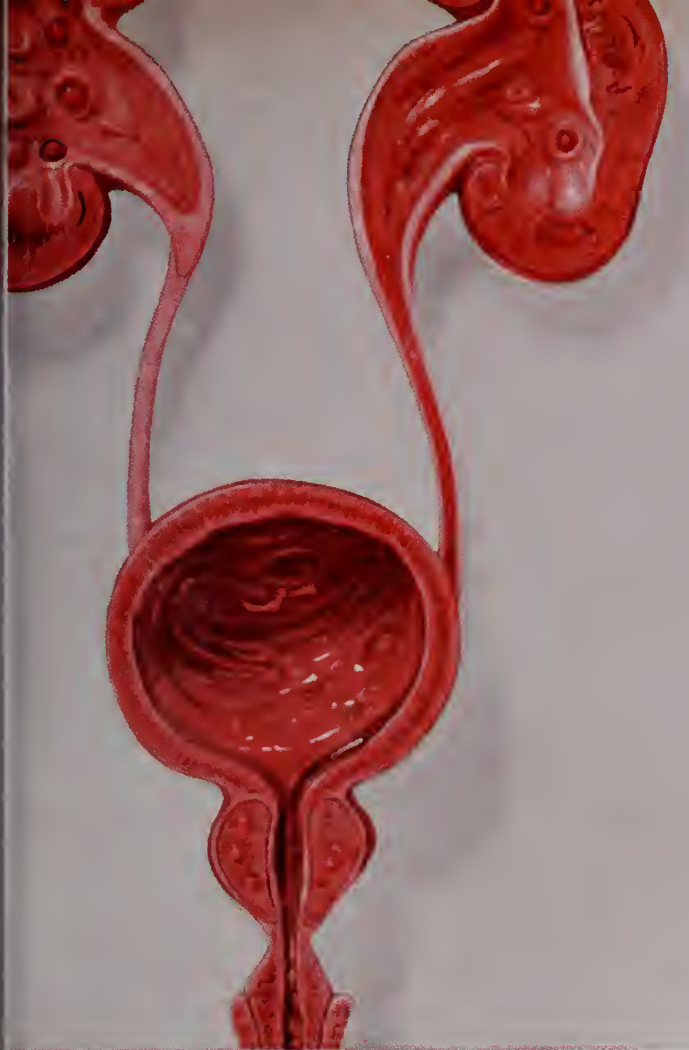
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pyelitis?
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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

dications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

de effects: Mainly mild, transient gastrointestinal disturbances; in casional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild sinophilia, reversible subjective visual disturbances (overbrightness of hts, change in visual color perception, difficulty in focusing, decrease in sual acuity and double vision), and reversible photosensitivity reactions. arked overdosage, coupled with certain predisposing factors, has produced ief convulsions in a few patients.

ecautions: As with all new drugs, blood and liver function tests are advisble during prolonged treatment. **Pending further experience, like most emotherapeutic agents, this drug should not be given in the first trimester pregnancy. It must be used cautiously in patients with liver disease or vere impairment of kidney function.** Because photosensitivity reactions have curred in a small number of cases, patients should be cautioned to avoid necessary exposure to direct sunlight while receiving NegGram, and if a action occurs, therapy should be discontinued. The dosage recommended r adults and children should not arbitrarily be doubled unless under the reful supervision of a physician. Bacterial resistance may develop.

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sage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times ily) for one to two weeks. Thereafter, if prolonged treatment is indicated, e dosage may be reduced to two Gm. daily. Children may be given proximately *25 mg. per pound* of body weight per day, administered in vided doses. The dosage recommended above for adults and children ould not arbitrarily be doubled unless under the careful supervision of a ysician. Until further experience is gained, infants under 1 month ould not be treated with the drug.

ow supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** convetently available in bottles of 56 (sufficient for one full week of therapy) and in ttles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

eferences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on quest. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: ntimicrobial Agents and Chemotherapy—1964, Ann Arbor, American ociety for Microbiology, 1965, p. 722.

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53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

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A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—which provide the combined action of both low-dosage progestogen and estrogen for the full treatment cycle—offer multiple contraceptive action that helps explain their unexcelled record of effectiveness. This report explores the secondary protective mechanisms against unwanted pregnancy offered by combined hormonal administration and the importance of the progestational agent in making such multiple contraceptive action possible.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has an adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) reverses the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that inhibits sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates a hostile cervical mucus

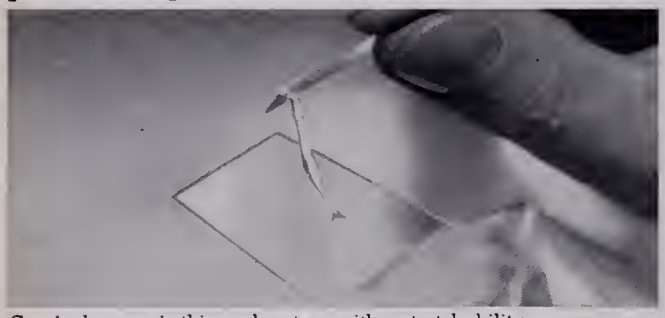
Normally estrogen activity during the fertile midcycle stimulates the production of cervical mucus. The mucus at this time is profuse and watery—allowing maximum sperm motility and promoting penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that diminishes the vitality of the sperm and impairs its powers of penetration.

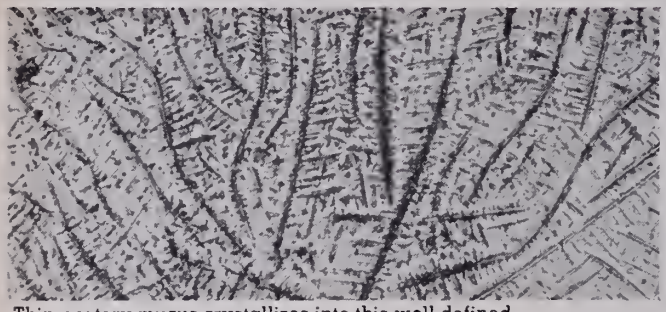
How hostile cervical mucus supports contraceptive action

The importance of these observations to the effectiveness of Norinyl-1 has been noted in a report on 89 patients taking this medication.* In all instances, cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception. *Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

Normal cervical mucus at midcycle in untreated patient permits sperm motility... promotes sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

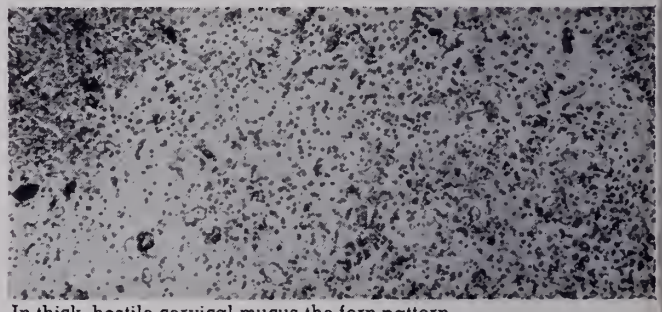


Spermatozoa appear healthy, are active and freemoving.

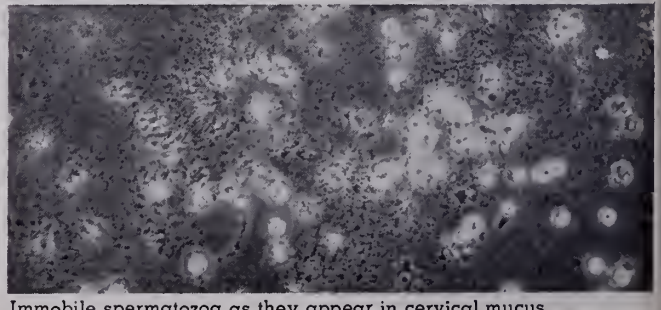
Hostile cervical mucus at midcycle produced by Norinyl-1 impairs sperm vitality... inhibits penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, hostile cervical mucus the fern pattern is poorly defined or absent.

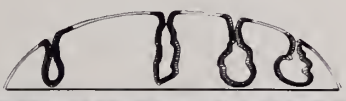


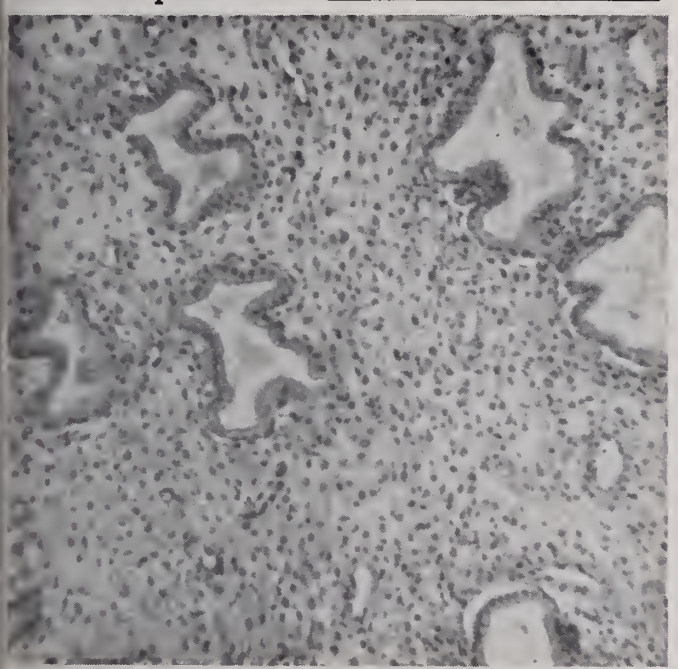
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

An endometrium unreceptive to nidation– another supporting contraceptive action of Norinyl-1

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier? Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy—progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient

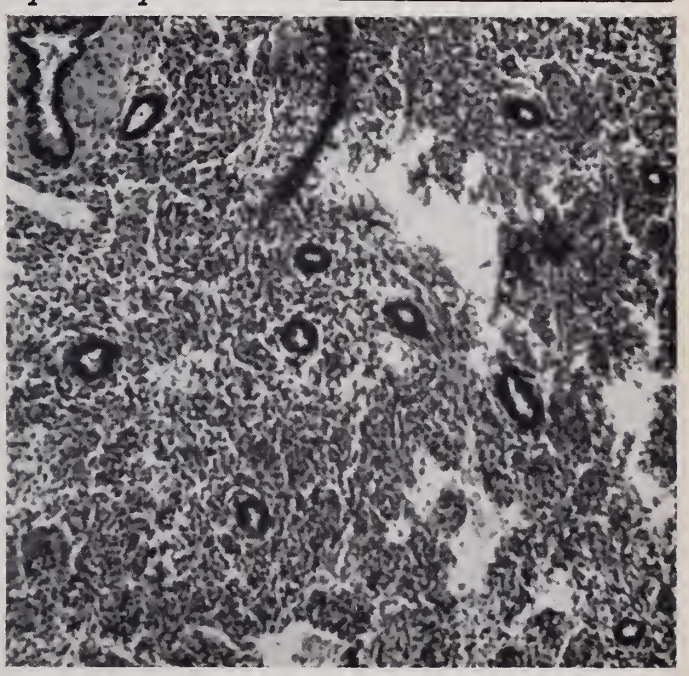




Normally the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Unreceptive endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase, suppressing glandular development. From day 11 on, secretory action is no longer present. The result is that during the latter half of the cycle the endometrium becomes unreceptive to egg implantation.

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on half the previous dosage

maintains ratio
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Norethindrone was first reported for use as a progestational agent i human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., a an oral contraceptive, is currently in use by over 2,000,000 wome Clinical experience now establishes that Norinyl-1 also amply meet the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: creased bromsulphalein retention and oth hepatic function tests, coagulation tests (crease in prothrombin, factors VII, VIII, IX a X), thyroid function (increase in PBI and bu nol extractable protein-bound iodine and crease in T^3 values), metapyrone test, pregna diol determination.

Other side effects reported to have occurr in association with use of this drug are di ness, hirsutism, pains in legs, back, chest a abdomen, dysuria, drowsiness, vaginal c charge, libido increased and decreased, er tions, hypermenorrhea, hypomenorrh increased appetite, G.U. infections, varico veins, abdominal fullness, acne, headac nervousness, allergies, blurred vision, pain eyes, and itching in eyes. *For complete clinic data, see package insert.*

Dosage and Administration: 1. One tablet Norinyl-1 is administered orally for 20 da beginning on day 5 of the menstrual cyc (Count day 1 of the cycle as the first day menstrual bleeding.) Repeat this dosage sch ule for each cycle. 2. If no menstrual peri occurs after a cycle of treatment (20 tablets) which patient adhered to the schedule, the tient must be instructed to resume taking t Norinyl-1 tablets 7 days after the previous day course was completed. For example, if t last pill of a previous cycle had been taken a Sunday, then a new cycle of treatment sho begin on the following Sunday. 3. In the p partum woman, it is recommended that t first cycle of treatment should begin on da of the first menstrual cycle. However, Norin should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 with mestranol 0.05 mg.)—Dispensers of 20 a 60 and bottles of 250 tablets.

norethindrone — an original steroid from

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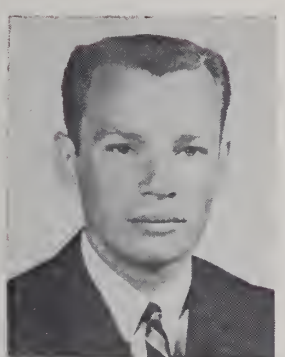
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These Syntex men serve the physician



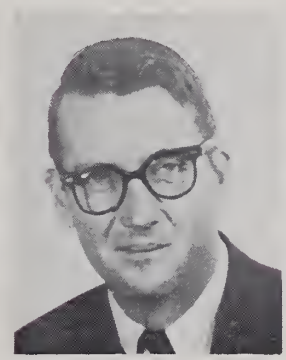
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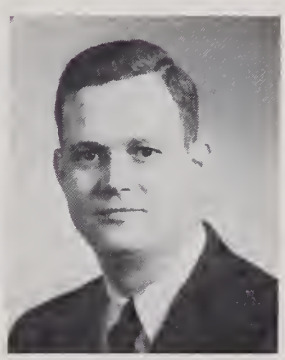
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INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

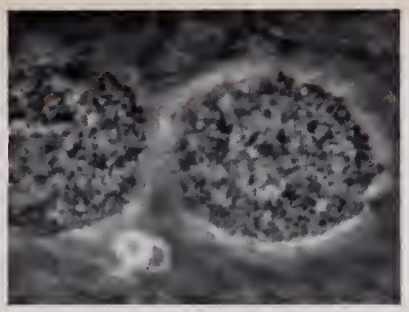


Visual evidence of how corticosteroids influence the inflammatory reaction

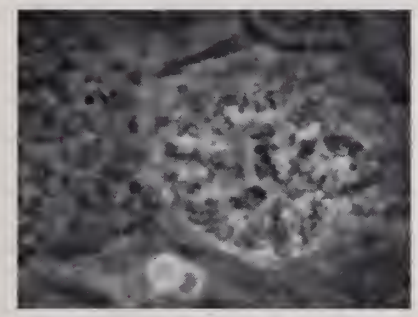
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



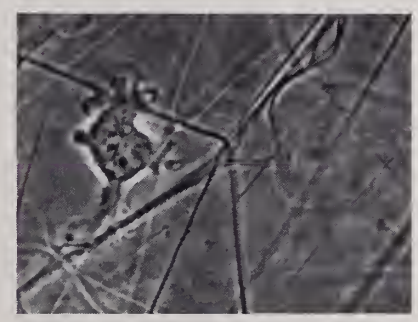
Phase-contrast microscopy showing mast cell before injury.



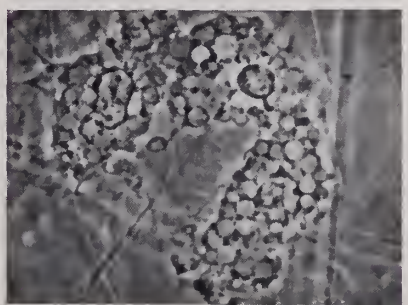
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid — Synalar (fluocinolone acetonide) — the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



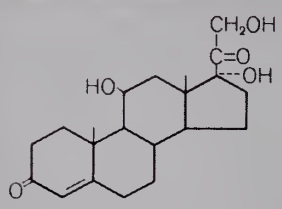
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses*, a film based on this study, is now available from your Syntex representative.

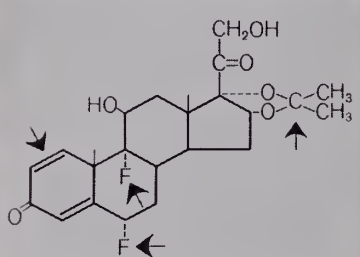
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

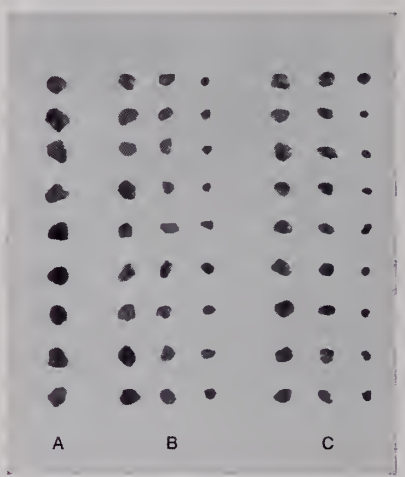


Fluocinolone Acetonide (Synalar)

- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B—injected with 1, 2 and 4 mg. of hydrocortisone—show progressively smaller thymuses as does Group C—injected with fluocinolone acetonide—but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Bornan, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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For inflammatory dermatoses... by any measure a topical corticosteroid of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards

MESSAGE FROM THE PRESIDENT



Dual Fees or Usual and Customary Fees?*

THE opinion of Kentucky physicians relative to the above question was clearly expressed in Resolution "A", passed by K.M.A.'s House of Delegates September 21, 1966. In the resolution, our K.M.A. legislative body endorsed the "Usual and Customary" fee concept as the method of payment most acceptable to Kentucky physicians for compensation of their professional services rendered recipients of governmental medical and surgical benefit programs.

Resolution "A" requested the appointment of a special committee to assist in the completion of a voluntary, confidential survey of physicians' charges so that we could *individually* establish our own current, usual and customary charges. I personally feel this approach is far better than having our fees calculated or estimated by a governmental agency not necessarily sympathetic to the voluntary practice of medicine.

The K.M.A. Advisory Committee which was appointed last November represents 19 major specialties of medicine and oral surgery. With the staff assistance of K.M.A. and Blue Shield, our committee prepared a survey booklet which, when completed by the majority of practicing physicians and oral surgeons, will substantiate on a confidential basis our current charges for the most important and frequently performed services and procedures of each major specialty.

Surveys were mailed March 22, to all licensed physicians and oral surgeons in Kentucky. As of April 21, about 50% of the doctors in private practice had returned surveys. However, we anticipate receiving at least 75% by May 1 and will be doing studies by the time this article is printed.

As chairman of the Fee Survey Committee, I want to express my personal thanks to the committee members who assisted in this project and to the many doctors who have responded by returning their surveys. Anyone who has not returned his completed fee survey is urged to do so, in the interest of helping preserve the voluntary practice of medicine.

ROY H. MOORE, JR., M.D.
KMA VICE-PRESIDENT, CENTRAL DISTRICT

This is the third of a series of articles written at the request of KMA President Robert E. Pennington, M.D., by the three KMA vice-presidents and the president of the Woman's Auxiliary to KMA. The first two articles appeared in the January and March issues of The Journal.

"Take a laxative" is a harsh sentence

Although there are more than 60 ethical laxatives available for the constipated patient, many, unfortunately, do not really produce an effect much like a normal bowel movement. Instead they whip the bowel, torment it and leave it irritated, inflamed and exhausted.
On the other hand, Dulcolax provides a nearly normal movement. Through its unique contact action, it induces the kind of natural contraction waves of the colon necessary for gentle, complete, comfortable bowel movements.
For your next constipated patient, try Dulcolax–the laxative with the gentle touch.

Dulcolax, brand of bisacodyl tablets (5 mg.)

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Dulcolax®
a gentle persuasion

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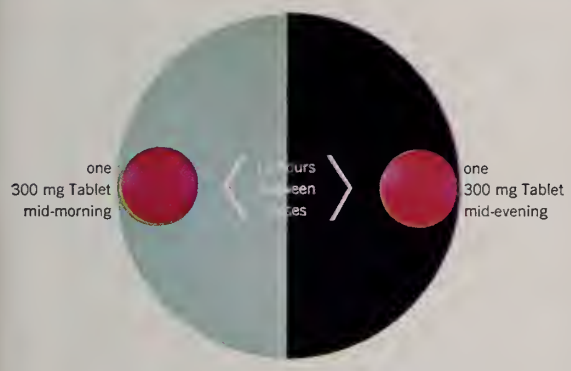


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DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

is effective b.i.d.



It's made for b.i.d.

ffective in a wide range of everyday infections — respira-ory, urinary tract and others — in the young and aged — ne acutely or chronically ill — when the offending organ-.ms are tetracycline-sensitive.

ontraindication — History of hypersensitivity to demethyl-hlortetracycline.

Warning — In renal impairment, usual doses may lead to xcessive systemic accumulation and liver toxicity. Under uch conditions, lower than usual doses are indicated nd, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or rtificial sunlight has been observed. Small amounts of rug and short exposure may produce an exaggerated unburn reaction which may range from erythema to evere skin manifestations. In a smaller proportion, pho-allergic reactions have been reported. Patients should void direct exposure to sunlight and discontinue drug at ne first evidence of skin discomfort.

Precautions and Side Effects — Overgrowth of nonsuscep-ble organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

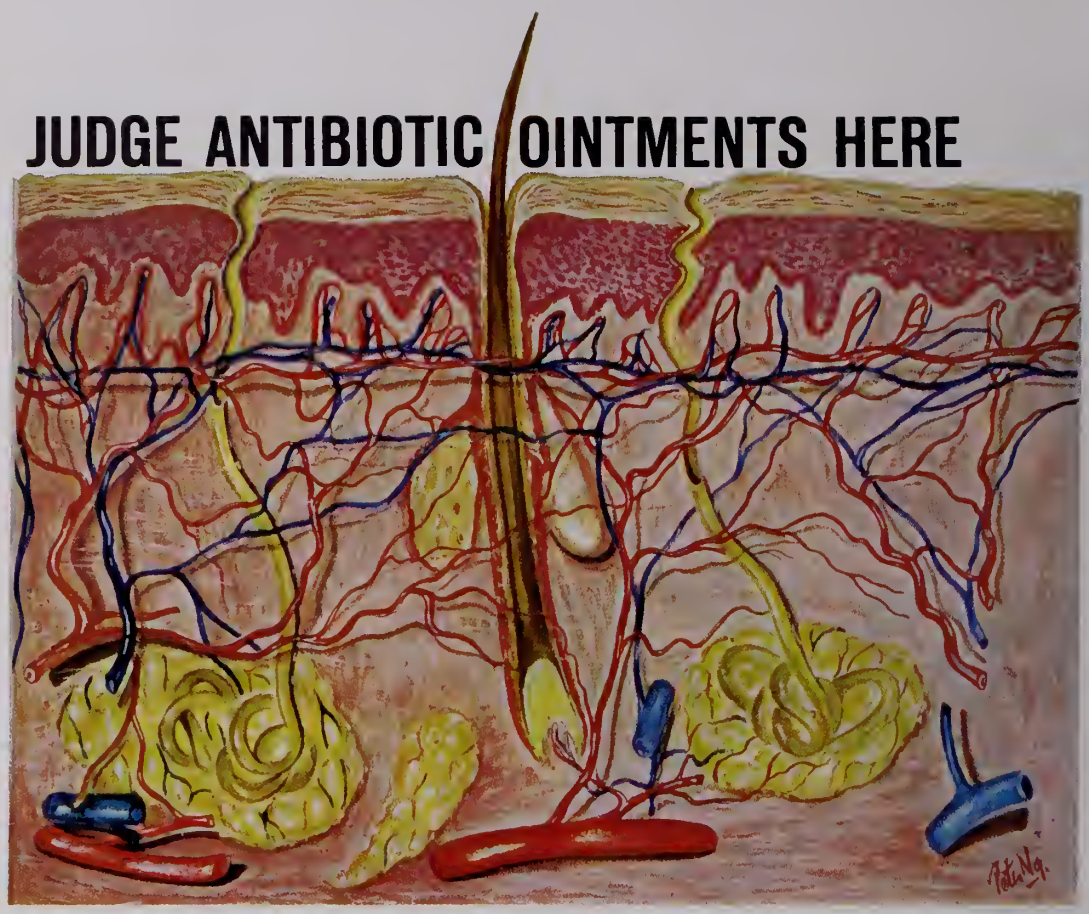
Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

EDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

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POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Night Leg Cramps...Frequent Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]



now...specific therapy for night leg cramps

QUINAMM™

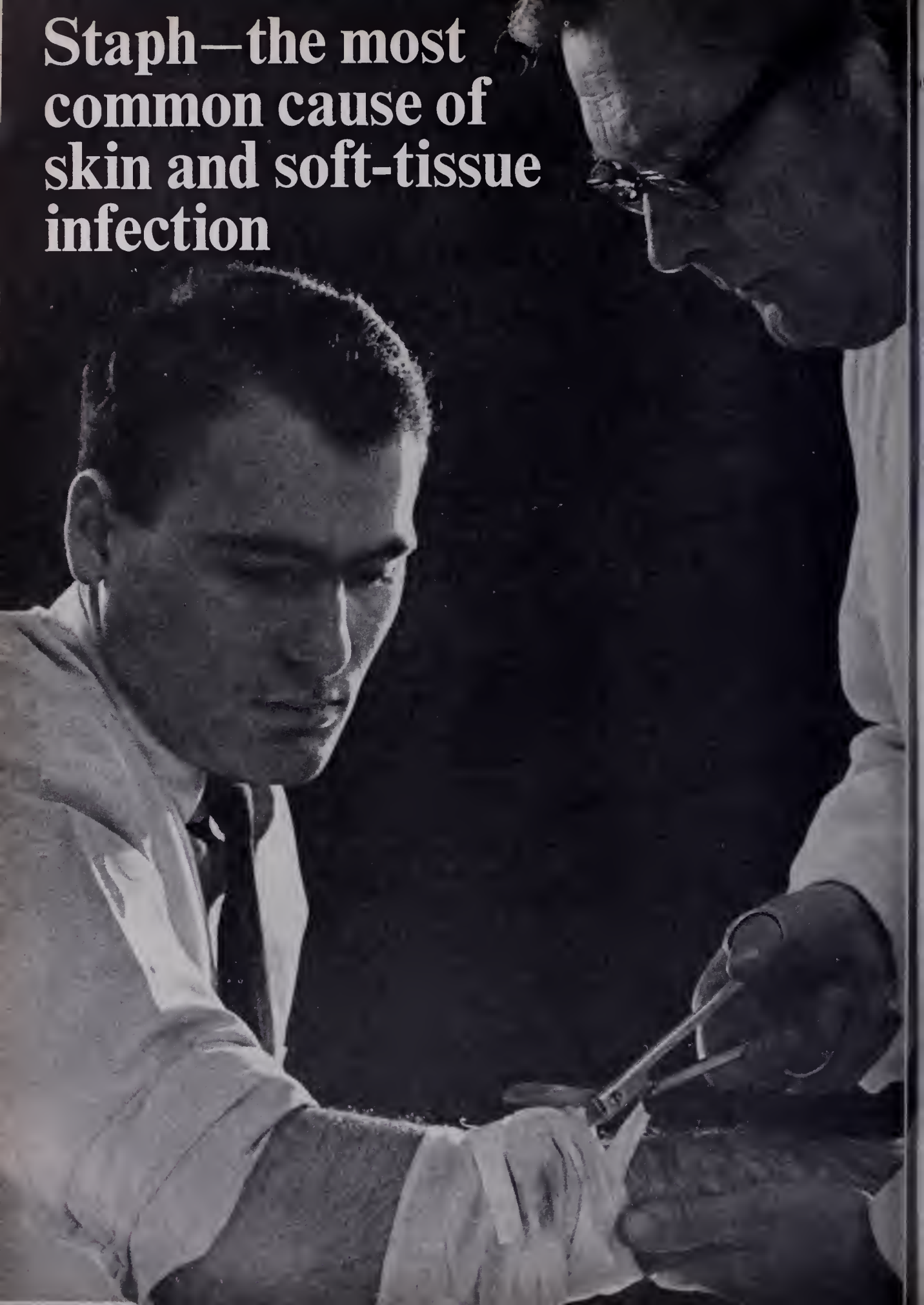
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

QUINAMM Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 4 grains (250 mg.) and Aminophylline 3 grains (200 mg.). **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **Caution:** Federal law prohibits dispensing without prescription.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

WALKER *Laboratories* Division of Richardson-Merrell Inc., Mount Vernon, New York 10551

Staph—the most common cause of skin and soft-tissue infection



..reliably controlled with specific therapy



A suitable dosage form for every staph situation

Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo*, therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY: 8:12.6**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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PUBLIC HEALTH PAGE

Planning For Comprehensive Health Services†

Russell E. Teague, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE 89th Congress passed legislation which will have far reaching implications for health services in Kentucky and in the nation. These changes are encompassed in P.L. 89-749 "Comprehensive Health Planning and Public Health Service Amendments of 1966". The intent of this law is to assure comprehensive health services for every individual within existing patterns of private professional practice of medicine, dentistry, and related healing arts. It is worth noting that just about every major health and medical organization supported passage of this legislation. Since this law will affect most of us in the health and medical fields it would seem desirable to become famailir with what it entails.

A tremendous and varied workload has been imposed on state agencies as a result of new programs authorized during the past several years. State health departments, especially, have had to assume new responsibilities in a variety of fields without a corresponding strengthening of their capacities. There are many different sources of federal support for health programs at state and local levels. Existing intergovernmental arrangements for health have not prevented undue rigidity in the financing of health programs, inability to use scarce professional health personnel efficiently, and the lack of sufficient coordination at the state and local levels.

"The Comprehensive Health Planning and Public Health Service Amendments of 1966" authorize grants to states for comprehensive health planning and to improve the existing programs of public health service. This new authority will provide grants through a variety of mechanisms for the planning and support of health programs, including demonstrations of new or improved out-of-hospital community health services.

The Surgeon General of the Public Health Service is authorized to make grants to states which have approved state plans for comprehensive state health planning. Such a plan must designate or establish a single state agency for administring the state's health plan and a state health planning council to advise such state agency. The states are to receive yearly block grants on the basis of the population and the per capita income of the states.

Grants may be made to any public or nonprofit agency or organization other than the state health planning agency to cover not more than 75 percent of the costs of projects for developing (and revising) comprehensive regional or local area plans for coordination of health services, facilities, and manpower. Grants may also be made to any public or nonprofit private agency, institution, or other organization to cover all or any part of the costs of projects for training, studies, or demonstrations for the development of comprehensive health planning.

Grants are authorized to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of special regional significance, (2) stimulating and initially supporting new health service programs, and (3) undertaking studies, demonstrations, or training designed to develop new or improved methods of providing health services.

The concept of a state health planning council is not so new or so different as it may sound at first thought. Over the past few years we have profited immensely from the thinking and advice of such groups as the Advisory Council for Health Facilities and the Advisory Council for Medical Assistance. This new council can be of similar assistance in the planning of all health programs. Physicians will be important members of this council. Their knowledge and experience will be drawn upon heavily by fellow members. It will present both a challenge and opportunity. By joining with other responsible leaders the physicians will have an amplified avenue of approach to solving the existing problems of gaps, overlaps and confusion existing today in many parts of our health programs.

Leaders in our field have generally come to accept the fact that most major problems, including health problems, are not confined to nor can they be solved

(Continued on page 538)

†*This article was prepared by Strawn W. Taylor, Director, Division of Research, Planning and Statistics, Kentucky State Department of Health.*



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1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

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Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

IN KENTUCKY

MAY

18-20 Kentucky Ob-Gyn Society, Annual Meeting, Continental Inn, Lexington

19-20 Symposium on Genetics and Birth Defects, Sheraton Hotel, Louisville

19-20 Eighteenth Annual Session Kentucky Surgical Society, Park Mammoth Resort, Park City

24 Kentucky Society of Internal Medicine Annual Meeting, Executive Inn, Louisville

JUNE

2 U. of L. Hospital Alumni Day, Executive Inn, Louisville

10 Conference on "The Hospital Emergency Room—1967: Problems and Proposals", Stouffer's Inn, Louisville

IN SURROUNDING STATES

MAY

16-19 Ohio State Medical Association, Columbus

21-24 National Tuberculosis Association, American Thoracic Society, and National Conference of Tuberculosis Workers, Penn-Sheraton. Pittsburg

JUNE

3-4 AMPAC Annual Workshop, Sheraton Park Hotel, Washington, D.C.

12-16 Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment, U. of C. College of Medicine, Cincinnati, Ohio

12-22 American Medical Association Annual Meeting, Atlantic City

15-19 American College of Chest Physicians, Atlantic City

16-17 American Geriatrics Society, Claridge Hotel, Atlantic City

17-18 American Diabetes Association, Atlantic City

18-22 American College of Preventive Medicine, Atlantic City

26-29 American Orthopaedic Association, Hot Springs, Virginia



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References: 1. Based on 1966 data from independent physicians' market survey organization. 2. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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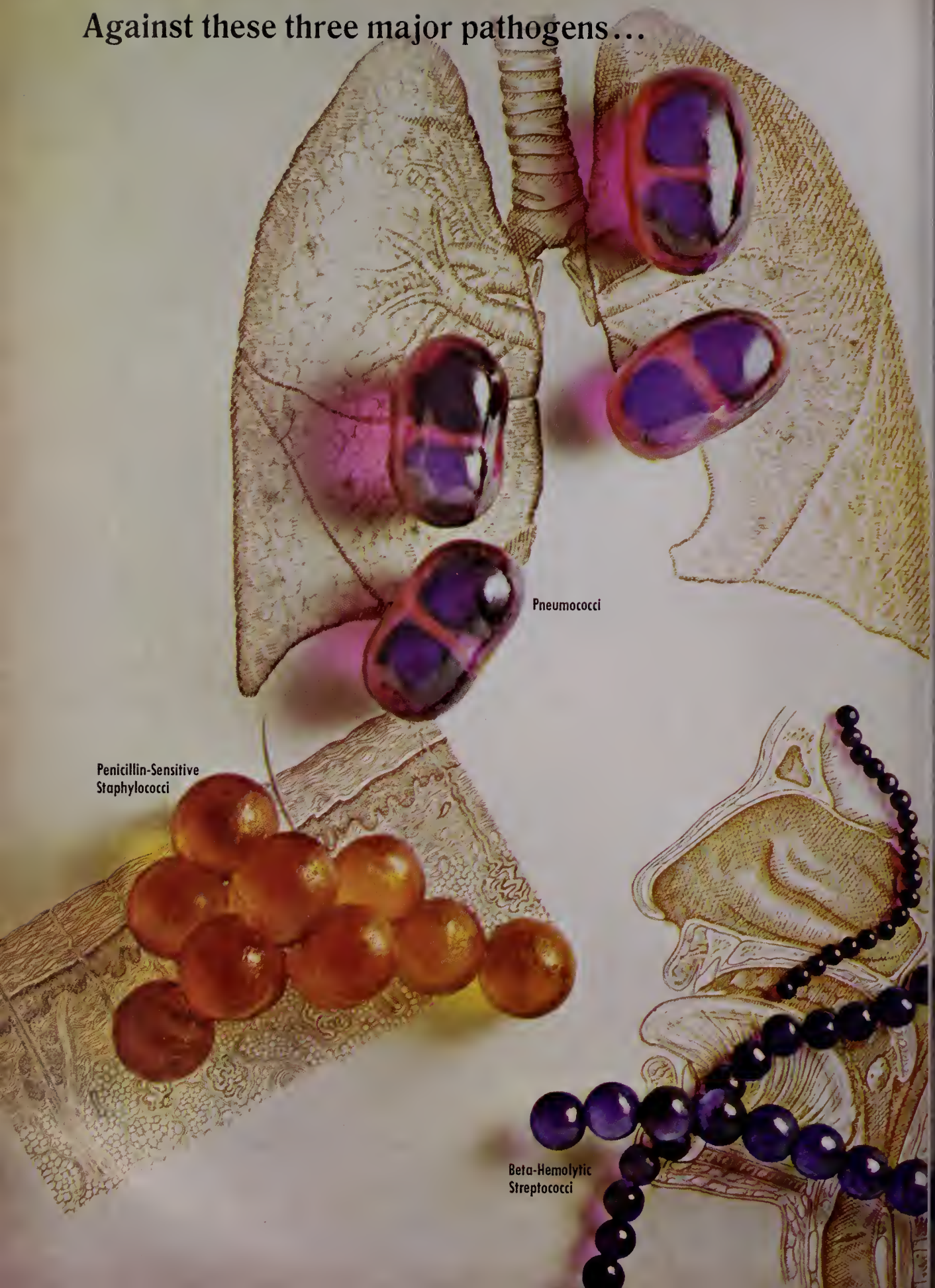
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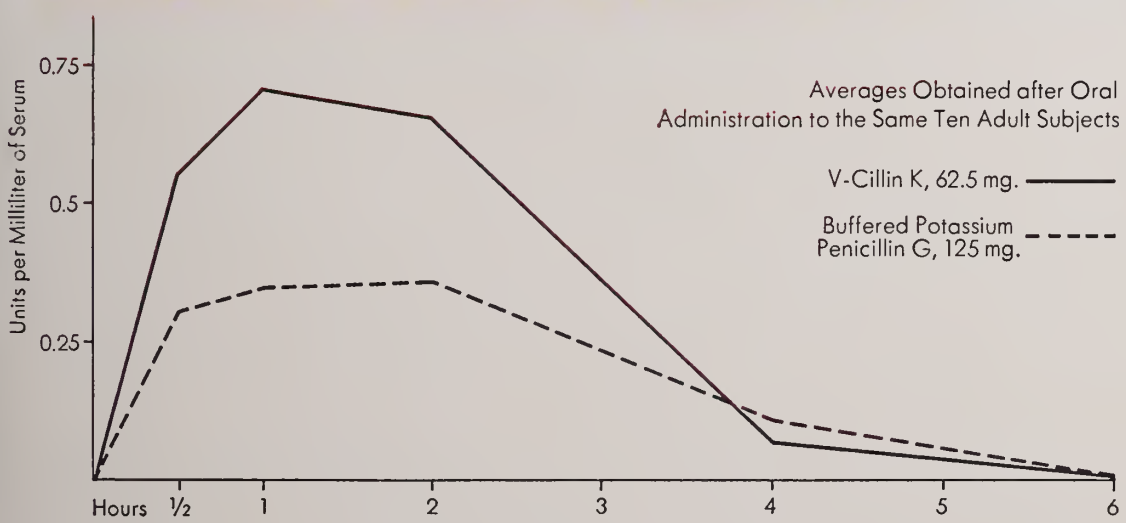
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Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



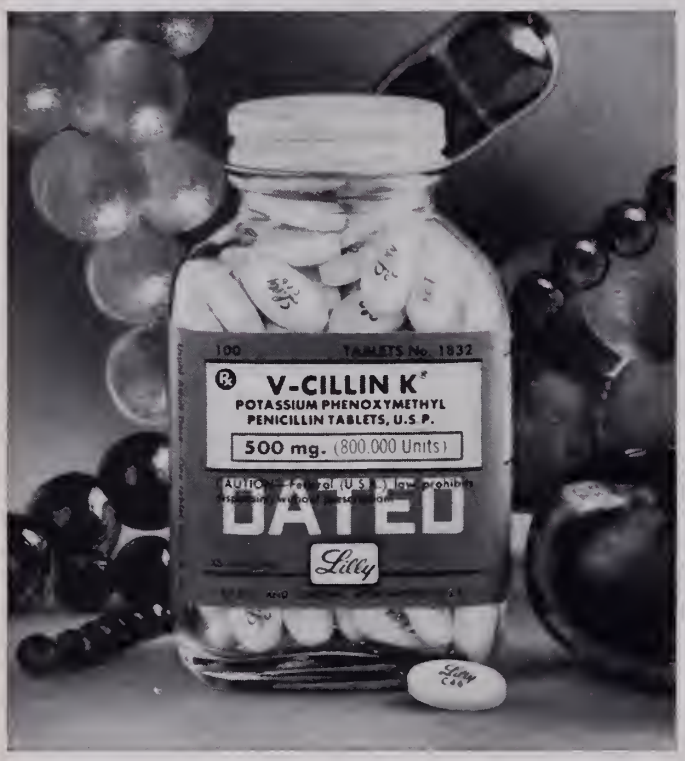
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Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for dela effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a pat with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with l parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stu (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowt pencillin-insensitive organisms. In such cases, its administration sh be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much common with administration of oral penicillin than with intramusc forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sig cant index of sensitization. The following hypersensitivity react associated with the use of penicillin have been reported: skin ra ranging from maculopapular eruptions to exfoliative dermatitis; caria; and reactions resembling serum sickness, including chills, fe edema, arthralgia, and prostration. Severe and often fatal anaphyl has occurred (see Warnings). Hemolytic anemia, leukopenia, thr bocytopenia, and nephropathy are rarely observed side-effects are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cilli Pediatric, the usual dosage ranges from 125 mg. (200,000 units) t times a day to 500 mg. (800,000 units) every four hours. For infc the daily dosage may be 50 mg. per Kg. of body weight divided three doses.

Beta-hemolytic streptococcus infections without associated b teremia may be treated with 200,000 to 400,0000 units three time day. Therapy should be continued for a minimum of ten days to pre development of rheumatic fever and/or other serious complicati Dosage for routine streptococcus prophylaxis in patients with a his of rheumatic fever or congenital heart disease may be 200,000 u once or twice daily. When such patients undergo tonsillectomy, t extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the of surgery, parenteral therapy should be considered. Mild to mo ately severe pneumococcus pneumonia has been treated effecti with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be g every six to eight hours in conjunction with indicated surgical pr dures.

For gonorrhea in males, 500 mg. (800,000 units) every four h for three doses may be employed; in females, 500 mg. every four h for six doses are recommended. Patients with a suspected lesio syphilis should have a dark-field examination before receiving penic and monthly serologic tests for a minimum of three months.

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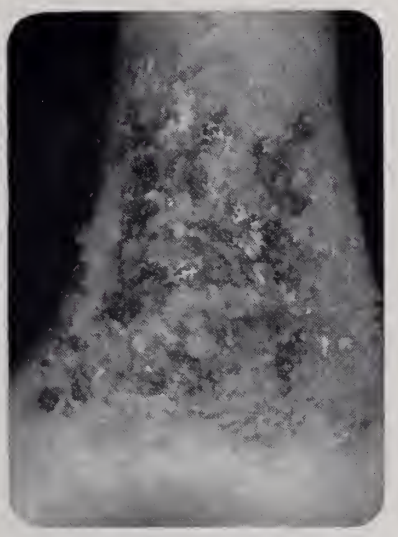
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Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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VOLUME 65 May 1967 No. 5

Physicians and Clergymen: Barriers to Interprofessional Cooperation†

DAVID A. STEERE, TH.D.*
Louisville, Kentucky

The American Medical Association's Department of Medicine and Religion began a nationwide program this year to promote discussions between physicians and clergymen of their mutual problems of patient care. Due to the timeliness of Doctor Steere's remarks, the editors agreed that this article should appear in the Scientific Section of The Journal.

In 1876 Dr. George M. Beard presented the paper entitled "The Influence of Mind in the Causation and Cure of Disease and the Potency of Definite Expectation" before the second annual meeting of the American Neurological Association in New York. In it, the famous neurologist maintained that disease might appear and disappear without the influence of any other agency than some kind of emotion. So new and startling was the presentation Dr. William A. Hammond remarked during the discussion that if the doctrine advanced by Dr. Beard was to be accepted, he should feel like throwing his diploma away and joining the theologians.[1]

Beard's paper possessed vision reaching far beyond his time. It anticipated the emerging concept of the person as a psychosomatic unity. And so did Dr. Hammond's offhand prophecy. Although I know of no doctors who have thrown away their diplomas from medical school, we witness a growing movement of physicians joining with clergymen and representatives of religion in genuine cooperation. The idea undergirding this is a simple one. If religion has anything to do with a person's feelings, and if a person's feelings have anything to do with his health, then religion may be an important factor in both illness and health.

Everyone is pretty much agreed that we need to cooperate. The American Medical Association has established its own Department of Medicine and Religion. Conversation between leaders in the field of religion and the behavioral sciences has been going on for years. I am concerned this morning, however, with cooperation at the grass roots level where physicians and clergymen are doing the job from day to day. And I want to deal with several barriers to this kind of cooperation as you and I confront them in everyday practice.

† *Informal remarks made to the Kentucky Medical Association Committee on Medicine and Religion, Louisville, Kentucky, September 21, 1966*

**Professor of Pastoral Theology and Director of Field Education, Louisville Presbyterian Theological Seminary*

[1] *Vide Nolan D. C. Lewis, "American Psychiatry from its Beginnings to World War II," American Handbook of Psychiatry, edited by Silvano Arieti, Vol. I (New York: Basic Books, Inc., 1959), p. 8.*

The Competence Barrier

The first we might call the competence barrier. All doctors have known quacks who practice in the cloth of the clergy. I seldom engage in a conservation with doctors about physician-clergy relationships but what I hear several stories about ministers who have upset or disturbed some patient, insisted upon baptizing a person with 104 degrees of temperature outside in the creek, or burst into someone's sick room with a feverish effort to convert him. One of the chief things these doctors seem to be saying is, "Don't hurt our patient."

There is little doubt that most doctors have come into contact with pastors who did not understand the nature of their patient's illness and who seemed to care little about him as a person. Those of us in theological education must acknowledge that the seminaries have been slow to adequately equip the minister with genuine competence in a ministry to the ill person. This is one area in we have lagged behind the times.

The situation of relative competence between the two professions has not always been this way. Ernest L. Turner gives us a glimpse of some of the annals of court medicine in the seventeenth century which I am sure the medical profession would like to forget.[2] His account of the treatment given King Charles II of England during his last days reads like a horror comic. The good king fell ill of kidney disease on Sunday evening. The next day a platoon of doctors descended upon the sick room and for the better part of a week tried everything with their patient except rest and privacy.

To drain off his blood they put cupping glasses on his shoulders. They scarified his flesh and tapped his veins. Then they cut off his hair and laid blisters to his scalp. This was followed by the application of plasters of pitch and pigeon dung to the soles of his feet. They blew hellbores up his nostrils to set him to sneezing, a refined technique to remove humors from his brain. They poured antimony and zinc down his throat. To clear his bowels they gave him a strong and brisk succession of clysters. To allay the convulsions that followed they gave him the spirit of a human skull. When he slept they woke him, when he spoke they silenced him. The following Thursday night the king's mind was still clear and undimmed. On Friday morning they drew 12 ounces of weak Stuart blood from his veins and gave him heart tonics. He did not die until noon, after apologizing for being so long in the process.

This was the caliber of medicine that was practiced in the seventeenth century court of Charles II. Remember that this is the century of the Westminster Confession of Faith which still stands as a credal tradition in Protestantism. It was a century after the great reformers, Martin Luther and John Calvin, wrote their lasting works.

We forgive you for lagging behind then. We ask you to forgive us for those pastors you have known in the past who have simply not understood your patients and their needs. The theological student who graduates from seminary today has usually received as much training in understanding human relationships as the graduate of medical school. He is ready to take his place as a competent professional in the care of the sick. During the past academic year 25 students in our own seminary were trained in clinical settings. This is better than half a class. These men served under the supervision of highly qualified chaplains in general hospital and mental hospital settings. They have learned to practice their own unique ministry to persons in illness. It remains for the practicing physician to come to know this type of seminarian when he graduates and to recognize him as the competent professional person he is.

The Full Treatment Barrier

A second barrier for us to break through is the full treatment barrier. The treatment of a given patient is not complete until the full resources available are mobilized to his aid. All of us would readily censor the minister who sets out by himself to treat pains in the abdomen, or severe headaches, or a broken limb. He is not a competent professional person if he ignores the obvious resources for the treatment of these ills which the physician possesses.

Correct me if I am wrong, but the physician may often ignore parallel resources among other helping professions. Let me mention a few instances where the pastor may play an important role.

[2] *The Doctor (New York: St. Martins Press, 1959).*

1. Patients in crisis—The patient whose illness is attended by some kind of personal crisis may well benefit from a pastoral relationship. The injured patient who lost someone close in an accident may well profit from talking this out with a concerned religious figure. Illness tends to accentuate difficulties in the family or problems in the work relationship. Careful attention by someone who can help the patient work through what must be confronted in going home is a useful adjunct to the convalescing process. A religious ministry is particularly meaningful in the case of terminal illness. Dr. Robert N. Butler has observed in dying patients the need to make a strenuous effort, both on conscious and unconscious levels, to bring order and meaning into life.[3] Surgery presents a crisis to most persons and the opportunity to voice anxiety and to affirm one's basic sense of trust is often a stabilizing influence.

2. Patients who present a problem of meaninglessness—The pastor may provide some of his greatest help to patients whose life seems to be surrounded with a sense of meaninglessness. Discouragement, loss of purpose, emptiness, and the inability to focus life in the future call forth fundamentally religious problems. Faith with imagination is one of the central elements in a person who addresses the future with hope. If he is able to imagine himself and the key situations of his life differently, he may gain new resources for living. Boredom and the loss of heart often signal the need for a rearrangement of what one anticipates from life. Realistic hoping in the midst of adversity is an essentially religious search for which the pastor is especially equipped to enter into the patient's life.

3. Patients with difficult adjustments—Another group of patients to whom the pastor may be of special help is that number who face long periods of convalescence, a readjustment of life patterns, or the working through of a loss. Genuine grief, whether it be over the loss of limb or organ, an important part of one's own life processes, or a loved one, signals the special need for a religious ministry. The heart patient who may be struggling with the sense of failure and the readjustment of vocational goals can benefit a great deal from careful conversation with his pastor.

4. Patients with real guilt—All of us encounter patients who are struggling with some sense of moral failure that is actual and genuine. This is to be distinguished from pronounced neurotic guilt which is a psychiatric problem. But for those locked in a realistic personal struggle for renewed responsibility in life, the opportunity to share this struggle with a pastor, who mediates a sense of forgiveness and renewal, can be of genuine benefit in the reordering of life.

Dr. Granger Westburg, a pastor who has shared the unique position of serving as a professor of religion and health in both the medical and theological schools at the University of Chicago, lists several other types of patients to whom the clergyman can have a special ministry: patients who are lonely or who are from out of town, patients whose anxiety is out of proportion to their illness, patients whose illness is functional rather than organic, and maternity patients who may be attaching many and diverse meanings to the coming of their child.[4] The physician who ignores these added resources in his program of treatment is passing by a number of relationships which may be of genuine benefit to his patients.

The Barrier of Referral and Consultation

A third barrier is the barrier of referral and consultation. As a pastor I have referred a great number of parishioners to physicians. This has been for any number of problems, both physical and emotional. Most pastors function in the same way. But referral and consultation cannot be a one way street if both physician and clergyman are exercising their full responsibility to the patient.

Why shouldn't the physician make appropriate referrals to the pastor also? I am thinking of a very fine general practitioner who referred a patient under treatment for a series of minor ailments to a particular minister in his area. He sensed that this housewife was bored and frustrated and very lonely. She had just moved from another community and found it difficult to establish healthy relationships outside the confines of her home. A

[3] *"Intensive Psychotherapy for the Hospitalized Aged," Geriatrics, V (September, 1960), 644-653.*

[4] *Minister and Doctor Meet (New York: Harper and Brothers, Publishers, 1961), pp. 73-81.*

quick telephone call to the pastor of her denominational preference served to bring this particular family into a very productive pattern of relationships which proved of genuine help in breaking through their isolation and estrangement.

Consultation between physicians and clergymen is essential to genuine cooperation. There is a natural reticence on both sides here. Many physicians have been burned through the inability of certain clergymen to exercise good judgment in handling confidences. Information about a patient's condition is privileged communication to be shared only in consultation with other professional persons in the interest of that patient's treatment. Does the clergyman belong on this consultation team? The answer is "no" if the clergyman is not a competent professional person and is unable to handle such information and to use it wisely. On the other hand, the answer is "yes" if the clergyman is known to be a competent pastor who has real need of information if he is to exercise his ministry in an appropriate way.

A physician hospitalizes a business man of fifty-five years of age who has been rushed to the hospital with advanced emphysema and other complications. He knows the pastor. He also knows the pastor has a special relationship with this particular parishioner. On the way out of the hospital he telephones the pastor, making his resources available to this man and to his family in a very difficult circumstance. "And you ought to know," he tells the pastor, "he's in real serious condition, so watch it." This type of information is vital for the pastor to have and the physician knows he will not only use it wisely but employ it skillfully in helping both the patient and his family.

Is there any way that the physician can benefit from consultation with the pastor? There is a natural reticence on the part of pastors to approach physicians, too. Often what he has to offer is not deemed important nor germane to the task at hand. How important is it for a physician to know something about the personal resources of a family in helping them cope with terminal illness? Of how much value can some knowledge of a person's home and work relationships be in certain types of illness that may show dimensions of anxiety? Frank and open consultation built on mutual trust can be of real value to certain patients. I am thinking of a very fine specialist in internal medicine who said to a campus chaplain, "This girl can go home any time that she wants to. I've checked her over thoroughly and find no organic cause of the pain she is having in her abdomen. What's bothering her?" The chaplain and the physician through mutual consultation worked out an approach to help this person deal, in a more mature way, with a difficult life situation that had led to her hospitalization.

The Time Barrier

Physicians and clergymen are both professional people. If they are good professional people, they work stringent schedules. One of the greatest encumbrances to cooperation is the time barrier. Meaningful referral and consultation can take place only where the two professional parties know one another, trust one another, and learn to work responsibly with one another. This takes time. I know of no answer to this one, except to say we all find the time to do those things which are most important to us. The question is: of how much importance is a good working relationship with those in other helping professions? A few lunches together, some time spent on the telephone, and a pause in the hall to converse for a very few minutes may pay rich dividends across the years.

The Role Barrier

A fifth barrier to cooperation is the role barrier. Here I refer to the absence of a clear understanding of what each other really does. A few among the sects still see the role of the physician as unwarranted tampering with the natural processes of God. Some clergymen remain suspicious of psychiatry and regard it as a threat to the patient's religious faith. But the competent pastor today knows a lot more about what the doctor is up to than the doctor knows about what he does as a pastor. He has read many of the doctor's books and been taught by his people in the school and in the hospital. Besides, with the rest of the American public he has watched such sterling exhibitions of modern medicine as those witnessed on "Dr. Kildare," "Ben Casey," "The Doctors and the Nurses," and "The Eleventh Hour." Unfortunately, no such public portrayals of the services of clergymen are available to the medical profession. In short, we know a whole lot more about you than you do about us.

I cannot, in a few minutes, explain to you everything that we are all about any more than you gentlemen could definitively set forth the role of a doctor in a few short sentences. But I can try to go to the heart of the matter in a brief way. Whatever else we say about the pastor, he is a general practitioner in human relationships. His role places him at the center of a community of people who have committed themselves to a fellowship with one another across the years. He embodies a general concern for the fullness and meaning of their lives. He is an administrative figure who helps coordinate and mobilize all the efforts of these people to care for one another and to live responsibly in the face of the immense problems our modern world creates. A very real part of his work is that of establishing durable relationships with people where they live, in their families, in their work, in their recreation, and in their worship and educational lives.

The good pastor comes to know his people, to understand them, which means standing by them, perhaps even underneath them, in the vicissitudes of life. If he is good at his work, he is one who bears hope, commitment, renewal, and faith in his presence. He does not senselessly condemn his people for their failures. He is not a party to inappropriate demands upon their personal resources. He lives with them and in a special way tries to release within them their God-given potential.

Beyond the personal resources which the pastor possesses are the resources of the community of faith which must not be discounted in the task of bearing help to people. Dr. Earl Loomis points to a custom among the Navajo Indians. When one of their tribe becomes sick of mind or body, instead of isolating him at the extremity of the camp, they bring him forward to the center of the village. All the people gather around him. There is singing and the dancing of tribal ritual. Often there is a big party and sometimes people drink a little too much. But the point is, when one of their members gets sick, the whole tribe gathers around him to celebrate the basic meanings of their common life. Instead of isolating the sick person, everyone gets busy and ushers him back into health.[5] It is the task of the pastor and the people whom he serves to gather round this sick and distressed person acting out the basic meanings and values of their religious faith, in an effort to help them recenter and renew life.

We break through the role barrier only when there is a mutual acknowledgment of the vitality of service rendered by each profession. This takes time, mutual referral and consultation, and the searching for competent parties who are willing to cooperate in each professional group. As our nation becomes more responsible in caring for its sick, it seems that the offhanded prophecy of Dr. William A. Hammond will be borne out. Although few physicians may throw away their diplomas from medical school, there will be a pronounced effort to join the theologians.

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[5]*Lecture on "Religion and Healing," New York, March 8, 1959.*

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Paracentesis in the Office Diagnosis of Blunt Abdominal Trauma†

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Abdominal needle-tap is a safe and rewarding office diagnostic maneuver. Limited heretofore to hospitalized patients to indicate a need for laparotomy, its use in the office or emergency room should facilitate decision on hospitalization of cases with suspected closed abdominal injury.

Introduction

THE decision as to whether or not to hospitalize is usually clear-cut in the average major highway, farm, or industrial accident. Victims of major accidents with minimal physical signs and an equivocal history of closed abdominal injury, presenting subjective complaints of abdominal distress only, may be difficult to evaluate, especially if coupled with a marked disinclination on the part of the patient to accept hospitalization.

The task facing the physician who first sees such a patient in his office is considerable. In the presence of a high index of suspicion, but in the absence of positive physical findings, definitive information may be obtained by the performance of a diagnostic abdominal needle tap, and the decision to hospitalize may thus become clear-cut.

Methods

In hospitalized patients with closed abdominal injuries, the value and the safety of diagnostic peritoneal tap of the abdomen has been amply demonstrated.[4] Yurko and William[6] have shown that patient groups subjected to routine abdominal taps were brought to definitive treatment earlier and required less blood replacement than those not so studied. (Fig. I) Giacobine and Siler[2] showed that even multiple punctures of the intestine using needles of 13 to 18 gauge were harmless in the experimental animal. These observers, as well as Drapanas and McDonald,[1] Williams and Zollinger,[5] and others, have reported an absence of complications, morbidity, and mortality from diagnostic abdominal needle taps in large series of human patients.

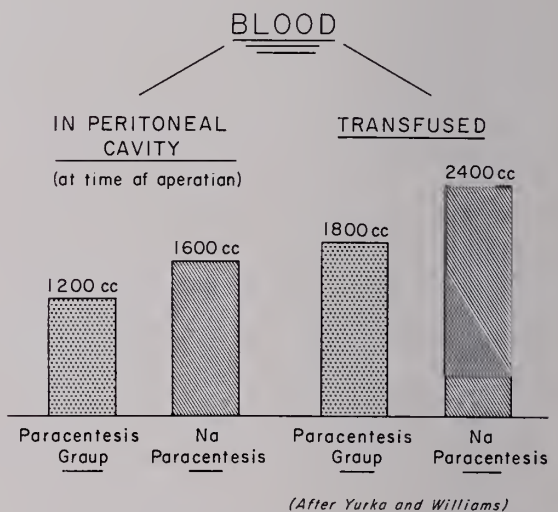


FIG. I. Homeostatic advantages of diagnostic peritoneal tap.

Giacobine and Siler[2] also showed that the ratio of positive taps was proportionate to the amount of fluid in the abdominal cavity, suggesting that cases seen shortly after injury might be expected to have less fluid (bile or blood) and more chance of a false-negative tap.

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Although, at first, proponents of this procedure suggested a 4-quadrant tap, most investigators experienced with the method now recommend bilateral flank taps only, taking care to position the patient carefully so as to favor accumulation of fluid at the site of tapping.

Root, et al.[3] have suggested the addition of peritoneal lavage, using a litre of sterile saline introduced through a catheter, to increase the percentage of accuracy which, as has been mentioned, is directly proportionate to the amount of free peritoneal fluid present. By this means, these investigators claim an accuracy of 100% in an acceptable series of patients. The method calls for the introduction of a nylon catheter through a special trocar, the use of which caused, in their small series, one serious complication due to bowel perforation requiring surgical repair. In the emergency room of a community hospital, this method might be appropriate, but in the physician's office, it is probable that the simplicity and complete safety of the needle tap unadorned by the introduction of cannulas or catheters will be found more practical. However, without sacrificing simplicity and safety, one may easily introduce and re-aspirate by syringe through the ordinary 18-gauge needle, 100 cc. of sterile saline, a solution available in ready-to-use form. This refinement might prove helpful in the negative office tap.

Technical Considerations

The equipment needed is simple and inexpensive. It is usually found in the average office or emergency room and consists of the following:

1. Two 20 cc. Luer-Lok syringes.
2. Two No. 18 short-bevel spinal anesthesia needles.
3. One 10 cc. Luer-Lok syringe.
4. One No. 25 ¾-inch hypodermic needle.
5. One No. 20 2-inch intravenous needle.
6. Two 100 cc. bottles sterile physiologic saline solution.
7. Two large tet tubes.

Technic

The anterolateral abdominal wall is anesthetized locally in the usual manner, choosing two homolateral flank areas well outside the rectus sheaths and epigastric vascular net. (Fig. II) With the patient positioned at a

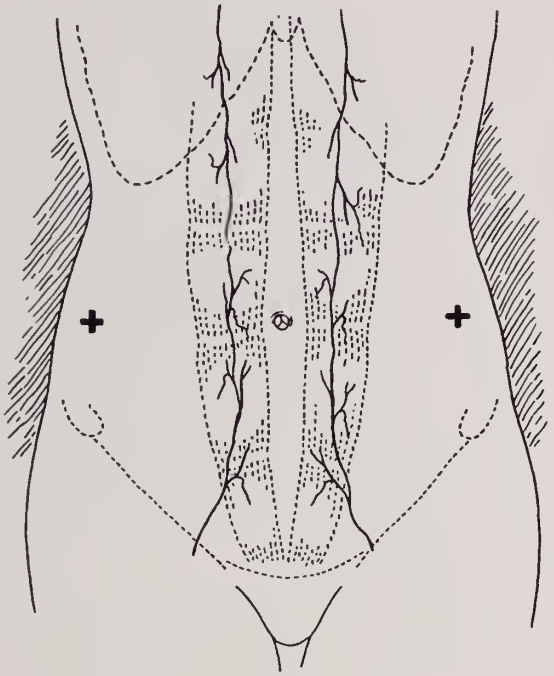


FIG. II. Sites (+) for bilateral flank tap.

30° lateral angle from the horizontal to allow accumulation of fluid, the dependent flank is tapped with the No. 18 spinal needle. A distinct sensation is transmitted as the peritoneum is punctured. If gentle aspiration with syringe reveals no free fluid, the needle point is withdrawn just outside the peritoneum, redirected at a different angle and reintroduced. (Fig. III) A maximum of three such attempts on each side is permitted. If negative, 100 cc. sterile saline is introduced through the needle into the peritoneal cavity and, after a few seconds, aspiration is again tried. If still negative for abnormal fluid (bile or blood), (Fig. IV) the needle is withdrawn and the patient is tilted laterally to the opposite side, and the procedure repeated on the opposite flank.

Findings

1. Bile-tinged fluid in any amount is abnormal, signifies hepato-biliary injury, and constitutes a positive tap.
2. The recovery of blood or bloody fluid in any amount over 1-2 cc., which does not clot, constitutes a positive tap.

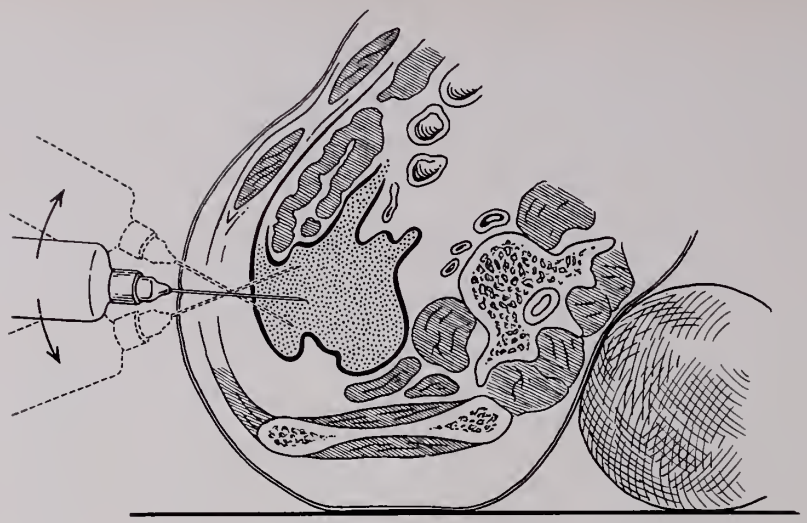
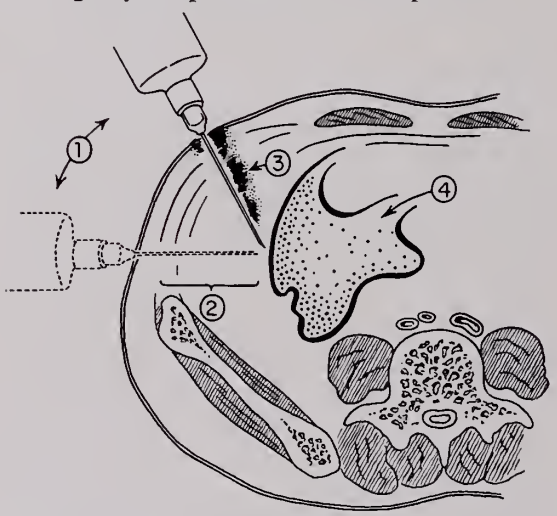


FIG. III. Technic of flank tap. Note positioning of patient using sand bag.

3. More than a faint pink tinge to any fluid recovered is considered due to free intraperitoneal blood, and constitutes a positive tap.
4. Even an equivocally positive tap is considered to be an indication for emergency hospitalization of the patient.



Causes of Error (Negative Tap)

1. Incorrect angle
2. Obesity
3. Scar tissue (old incision)

} *Needle fails to penetrate peritoneum*

4. Insufficient free fluid

FIG. IV. Reasons for false-negative tap.

The recovery of intestinal content is usually unmistakable, and is an indication for withdrawal and discard of the needle employed and the reintroduction of a fresh sterile needle in a different plane as already described.

The recovery of blood which clots is due to tapping a vessel of the abdominal wall or extraperitoneal space.

Summary

Diagnostic needle tap of the abdomen is a safe, practical procedure, suitable for office or emergency room.

It should prove especially worth-while in the evaluation of the patient with suspected closed abdominal injury, and should facilitate decisions on hospitalization of such patients.

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Delayed Rupture of the Spleen†

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The clinical profile of delayed splenic rupture is presented. Methods of expediting the making of the diagnosis and splenectomy are discussed. Ten cases from the St. Joseph Infirmary were studied.

THE purpose of this paper is to re-emphasize the serious nature of delayed rupture of the spleen following blunt abdominal trauma. Traumatic rupture of the spleen is the most frequent serious intra-abdominal injury following blunt abdominal trauma.

Material

The hospital records of St. Joseph Infirmary, Louisville, Kentucky from 1955 to 1965 contain 40 cases of traumatic rupture of the spleen secondary to blunt abdominal trauma. The mean age of these patients was 25.6 years, the range being 4 to 67 years. There were 26 males (65%) and 14 females (35%). All were Caucasian. Thirteen (32.5%) had fractured ribs. Delayed splenic rupture occurred in ten patients (25%) of this series. The mean latent period was 93.5 hours. The extremes of the latent period ranged from 64 to 144 hours. All of our delayed splenic ruptures were detected in the first week after injury. Of the 10 patients with delayed splenic rupture, two had fractured ribs (20%) and eight (80%) did not. Of the 40 patients in this study, 12 had associated intra-abdominal injury and 28 did not. None of the patients with delayed splenic rupture had associated intra-abdominal injury. The records were thoroughly gleaned in an effort to find a precipitating factor or factors to account for the secondary hemorrhage in the patients with delayed splenic rupture. None were found. The abdominal quadrant of maximum pain and tenderness was recorded and was as follows:

Left upper quadrant	28
Right upper quadrant	5
Left lower quadrant	1
Right lower quadrant	2

In three patients, abdominal pain and tenderness was generalized to all four abdominal quadrants. Kehr's sign was recorded in 12 of the 40 patients in this series. Of the 10 patients with delayed splenic rupture, four had a positive Kehr sign.

Diagnostic x-rays revealed one patient with an enlargement of the spleen suggestive of a subcapsular hematoma. Two patients had x-ray findings of serration of the greater curvature of the stomach and neither of these patients was in the delayed splenic rupture group. X-ray interpretation of one case included the statement that the stomach and spleen were above the left hemidiaphragm. Other x-ray reports included statements as to haziness in one or more abdominal quadrants but nothing more specific to indicate a splenic rupture. No radio-isotope splenic scans were done. Abdominal paracentesis was done in four patients, and three of these were positive for blood. Only one of the positive abdominal taps was in the group with delayed splenic rupture. The mortality rate for the entire series of 40 patients was 17.5% and the mortality rate for the 10 patients with delayed splenic rupture was 20%.

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Case #1

Mr. W.M.T. case #55-13009. This 58 year old white male was admitted to the St. Joseph Infirmary on 9-3-55 after having been in an automobile accident 24 hours previously, at which time he was admitted to the Louisville General Hospital, where casts were applied to an open fracture of the right tibia and a closed fracture of the right forearm. The patient also incurred lacerations over the right eye and the left occipital region. An additional clinical diagnosis was possible skull fracture. At the time of admission, the patient was mentally confused. His blood pressure was 122/86. Abdominal examination was normal. He was treated with prophylactic penicillin, elevation and ice bags to the extremities. Morphine was given for pain. His hemoglobin was 8.7 grams, RBC 3.44 million, WBC 15,800 with 63% segmented neutrophiles, 2 Stab neutrophiles, 20 lymphocytes, 8 monocytes, 6 eosinphiles, and 1 basophile. Urinalysis revealed cloudy, bloody urine with 2+ albumin and RBC and WBC too numerous to count. X-rays showed a comminuted fracture of the right ulna in the distal third, a comminuted fracture of the right radius and an oblique, comminuted fracture of the right tibia. Chest x-ray revealed right lung pneumonitis and elevation of the right hemidiaphragm. The patient responded satisfactorily to conservative treatment until 9-6-55 when he became hypotensive. No pulse or blood pressure could be obtained, and although he was given caffeine sodium benzoate, oxygen and Coramine, he died at 2:55 a.m. No blood transfusions were given during this hospitalization.

Autopsy revealed 500 cc of blood in the peritoneal cavity, 800 cc of blood in the right pleural cavity and somewhat less blood in the left pleural cavity. No pneumonia or pulmonary congestion was found. The spleen weighed 400 grams and there was a laceration of the capsule of the spleen with rupture and hemorrhage into the peritoneal cavity. Kidneys, liver and urinary bladder grossly were normal. The brain was edematous, weighed 1300 grams and there was a subdural hematoma in the left occipital region.

Microscopic examination of the spleen revealed a laceration with an area containing fresh hemorrhage. It can be concluded that the contracted blood volume from the multiple fractures and right hemothorax was not corrected prior to the hemorrhage from delayed rupture of the spleen. The patient went into shock and died before blood transfusions could be given. Hypovolemic shock secondary to delayed rupture of the spleen with hemorrhage was thought to be the cause of death even though he did have an occipital lobe subdural hematoma. Abdominal paracentesis would have expedited exploratory laparotomy and splenectomy.

Case #2

Mrs. G.P. case #55-7470. This 30 year old white female was admitted to the St. Joseph Infirmary on 5-30-55. She had been thrown from an automobile and another automobile had run over her. She was in shock even though whole blood and Levophed had been given. Her blood pressure was stable at 120/80 on admission and initial physical examination revealed dyspnea, Cheyne-Stokes breathing, respirations 28 and a pulse rate of 160, multiple rib fractures, and scattered rales in both lungs. Her heart rhythm was regular and there were no murmurs. Her abdomen was soft and no masses were palpated. She had a pelvic fracture, sutured laceration of the right knee and abrasions of both knees. The patient was given one pint of blood, a Levophed i.v. drip, tetanus toxoid, Demerol, intravenous fluids and prophylactic penicillin. Admission laboratory studies revealed a Hgb. of 10.1 grams, 3.65 million RBC, 22,200 WBC with 93% neutrophiles (67% nonsegmented neutrophiles, 26% Stab neutrophiles), 6% lymphocytes, 1 monocyte. Urinalysis was negative except for a trace of albumin, an occasional red blood cell and 4-6 WBC/hpf. Electrocardiogram revealed sinus tachycardia. X-rays showed fractures of the left 9th, 10th, and 11th ribs, the right 7th rib, a closed fracture of the left ala of the sacrum, avulsion of the left transverse process of the fifth lumbar vertebra, a closed fracture of the superior and inferior pubic rami bilaterally, cloudiness of both lungs and slight cardiac enlargement. On 5-31-55 the patient was started on a soft diet. On 6-1-55 the patient's pulse was thought to be stronger, there was good urinary output and her blood pressure was 144/70. On 6-2-55 she developed dyspnea and cyanosis, her blood pressure was

120/80, pulse 140, and she had Cheyne-Stokes respiration. Stat electrocardiogram revealed a paroxysmal auricular tachycardia of 160. She was rapidly digitalized with digitoxin and was given Coramine and oxygen. While trying to get a portable chest x-ray on her, she died.

Autopsy findings: The abdomen was distended. There were abrasions of the right flank and right thigh. The peritoneal cavity contained 1000 cc of blood, mostly liquid but with some clots. The left pleural cavity contained 1000 cc of serosanginous fluid and a smaller volume of the same type of fluid was found in the right pleural space. Parietal pleural ecchymoses were present, the lungs were edematous and there was some atelectasis of the left lower lobe. The heart grossly was negative. The spleen weighed 400 grams, and there was an 8 cm. laceration of the splenic capsule with a 1 cm. gap. There were clots attached to the spleen and much hemorrhage into the splenic pulp. The liver, kidneys, gastrointestinal tract and urinary bladder were all grossly normal. The retroperitoneal space contained a large amount of hemorrhage. The pancreas grossly was normal. Microscopic examination of the spleen revealed necrosis and hemorrhage of the splenic pulp. The lungs were congested and edematous.

The serious nature of this patient's intra-abdominal injuries was not appreciated by the attending surgeon despite the history that an automobile wheel had run over her abdomen and lower chest. The contracted blood volume was not corrected before the patient had the hemorrhage from delayed rupture of the spleen. The tachycardia was probably secondary to anemic anoxia. In retrospect the patient should have had correction of blood volume deficit, bilateral thoracentesis, and exploratory laparotomy when her condition permitted. Abdominal paracentesis would have expedited exploratory laparotomy and splenectomy.

Discussion

Baudet, in 1907, called attention to an interval of quiescence that occasionally followed splenic trauma, in which bleeding ceased only to resume sometime beyond 48 hours after the splenic injury.[3] This has become known as the latent period of Baudet. In 1966, Sizer et al, reviewed the English literature from 1866 to the present and collected 306 cases of delayed splenic rupture that had been reported and added six cases of their own.[8] In this collected series, the greatest number of cases occurred during the third decade of life and males predominated three to one. In most cases there was no other associated injury. Rib fracture in the left side was the most frequently associated injury and was present in 10% of these cases. It was present in 20% of our cases with delayed splenic rupture. Fultz and Altmeier reported a 40% incidence of associated rib fractures and warned that the possibility of splenic rupture should always be kept in mind in any patient with fractures of any of the lower left six ribs.[5] R.D. Williams states the association of rib fractures with splenic rupture has been found in only about one of every five patients.[12]

Several types of splenic injuries have been recognized. There may be a minor laceration of the capsule or an intrasplenic or subcapsular hematoma and there may be a pedicle tear. The omentum, stomach or organ adhesion may momentarily tamponade a capsular laceration. A time lag is necessary for a slowly enlarging subcapsular hematoma or intrasplenic hematoma to rupture through the splenic capsule.

In Sizer's collected series of 312 patients, the latent period was less than one week in 50%, delayed ruptures occurred in another 25% during the second week, and in 10% the delayed ruptures occurred after one month. The longest reported interval was two years following initial injury. All of our delayed splenic ruptures were detected in first week after trauma. Secondary hemorrhage, according to Sizer, is often precipitated by a sudden increase in intra-abdominal pressure with coughing or straining at stool. In our series we could find no precipitating factor.

Altmeier states that the diagnosis of delayed splenic rupture can be made clinically without difficulty if the examiner is familiar with the signs and symptoms. In the collected series reported by Sizer, only 20% of the patients had left upper quadrant abdominal pain. In our series of 40 patients with splenic rupture secondary to blunt abdominal trauma, 28 had left upper quadrant abdominal

pain and tenderness. Sizer states that Kehr's sign was present in 17% of 306 cases that they reviewed. In Altmeier's series it was present in 12 of 15 patients. R.V. Byrne[4] states that the presence of a positive Kehr's sign is found to be directly proportional to the number of patients who are questioned concerning pain in the left shoulder and neck. Hamilton Bailey states that frequently the patient will not volunteer this information unless he is specifically asked about pain in the left shoulder.[1] R.D. Williams states that pain in the left shoulder occurs in nearly 75% of the patients with splenic ruptures and is diagnostically significant. He advocated placing the patient in the Trendelenberg position to precipitate left shoulder pain.

Sizer found that hematocrit readings and hemoglobin determinations were significant, but reflected only blood loss and not specifically splenic hemorrhage. R.V. Byrne says that blood pressure readings were not consistently lower in cases of delayed hemorrhage and did not consistenty fall as the rate of intra-abdominal bleeding increased.

Fultz and Altmeier stated that perhaps the best diagnostic aid were roentgenographic studies of the abdomen which showed medial or anterior displacement of the stomach with irregularity or displacement of the splenic flexure. In four of the six cases reported by Sizer the x-rays were of diagnostic significance.

Dullness to percussion in the abdomen was present in 10 of the 15 patients with delayed splenic rupture in the series of Fultz and Altmeier. This is known as Ballance's sign[2] and McIndoe says that it should be found in the majority of cases at some time in the clinical course.[6]

Sizer states that if symptoms persist or localize, a four quadrant abdominal paracentesis should be done. In the series of Stivelman et. al., abdominal paracentesis revealed intra-abdominal bleeding in 36 of 42 patients and did not cause any complications.[11] DeBakey believes that four quadrant abdominal tap was often helpful but no reliance should be placed on negative tap.[7] C.B. Wilson et. al., reported a 95% accuracy with abdominal paracentesis at the Charity Hospital in New Orleans.[13] Abdominal paracentesis is a safe procedure[10] and we recommend the technique of Stephens and Amis[9] which consists of insertion of a polyethylene tube through a 13 gauge BD needle. If no blood or fluid is obtained by aspiration after the patient's position has been repeatedly

(Continued on page 540)

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Sudden Hearing Loss: A Medical Emergency

Francis J. Peisel, M.D.*
Louisville, Ky.

Sudden, perceptive hearing loss, if treated early by a vasodilating regime, has an excellent chance of recovery. Recovery is directly related to the time between onset and treatment.

I HAVE noted over the past few years that many physicians when presented with a patient with sudden, severe hearing loss, be it unilateral or bilateral, do not necessarily consider this to be an emergency. The patient is either treated for eustachian tube blockage or labyrinthitis or Meniere's disease or else referred on a routine non-emergency basis to the specialist. Indeed, the patient himself may not consider it an emergency. The patient's and physician's attitude is in direct contradistinction to partial loss of any other special sense, such as vision, voice or balance. These attitudes are understandable because until recently we had very little to offer the patient, but now we do have a valuable and effective treatment. As time passes, it will be less understandable and less forgivable if these patients are not treated on an emergency basis. The main purpose of this paper is to familiarize the non-otologist with the diagnosis, available treatment and results thereof in sudden hearing loss.

Definition

By sudden hearing loss we mean the development of a sensory-neural hypacusia in a previously normal-hearing individual over a period of one week or less without apparent reason in an otherwise healthy patient. The majority of our cases have noticed hearing loss upon awakening. We have no clinical explanation for this. It is strange but many people cannot determine with accuracy when hearing loss took place. It is wise to give these people the benefit of doubt and treat them.

Theory

Theoretical causes of hearing loss are many. The causes remain theoretical because the inner ear is difficult to examine either ante or post mortem. As proof of this, it might be stated that as well known an entity as Meniere's disease has only been proven in a handful of cases by postmortem study throughout the decades. The majority feel sudden hearing loss is on a vascular basis, namely *spasm,* although other mechanisms have been advanced, such as hemorrhage, virus infection, blood sludging, thrombosis, arteritis, edema, hydrops or combinations thereof.

Pathology

Williams[2] and Hilger[3] have described the mechanism of spasm as autonomic dysfunction. In essence, as in other parts of the body, arteriolar spasm is followed by anoxia which results in injury to the endothelium, sludging of the blood, release of toxic substances, and a disturbance of local electrolytes and fluid balance leading to loss of function.

Diagnosis

Diagnosis is made by history and audiometric findings in the presence of completely negative ENT exam.

Audiograms may show any type of pattern, that is, high tone loss, low tone loss, or a flat loss may be present but it is always predominantly sensory neural. Tinnitus was present in 86% and vertigo in 37% of Sheehy's[1] 223 patients. In lieu of audiograms, tuning forks may be used. In the clinical case, the Weber will be referred to the good ear and and Rinne will show air conduction greater than bone conduction on the involved ear.

*Otolaryngologist practicing in Louisville.

Treatment

All treatment is directed against spasm. The method advocated here is taken directly from the method advocated and published by Sheehy[1]. It is as follows:

1. IV Histamine. As soon as the diagnosis is established, intravenous histamine is given twice a day on three consecutive days. The solution contains 2.75 mgms. of histamine phosphate in 250 cc of normal saline or glucose and is administered at a rate of 50 to 60 drops per minute to the tolerance which is manifested by severe flushing with headache.
2. Following completion of this series, 0.1 cc of histamine phosphate, 1:1,00,000 dilution, is administered subcutaneously twice a week.
3. Histamine 1:10,000 is given, to be taken 2 drops, sublingually, twice a day.
4. Nicotinic acid in flushing doses is prescribed before each meal. Other vasodilators may be substituted, such as Roniacol®, Arlidin®, or Vasodilin®.
5. Diuretics.
6. Vitamin C, 300 mgms. daily.

Treatment should be continued for 6 weeks and, if no encouraging results are seen by that time, treatment may be stopped. Treatment is usually continued for about 6 weeks after the hearing has returned to normal. Other treatments have been recommended, such as heparinization, intravenous procaine and stellate ganglion blocking. More recently, John Shea, in an as yet unpublished work, has added CO - O inhalation to the therapy, feeling this is a proven vasodilator.

Results

Time seems to be the most important factor. If treatment is instituted within 4 days, 62% recover; if within 2 weeks, 53%; if within 6 weeks, 47%; but if after 6 weeks, only 5% recover. In general, if treatment is instituted within 6 weeks, 50% of the patients will recover their hearing.

During 1964-65, I have seen 8 cases of this entity. Illustrative case reports follow:

CASE #1

A thirty-three-year old airman stated that upon awakening on 18 Feb 1964 he noticed severe loss of hearing in the left ear accompanied by a low "roaring." He stated his hearing had been normal previously. He reported to his dispensary that morning and was referred to Tripler General Hospital on a routine basis. He was seen on 28 Feb 1964, 10 days after the onset. A review of his Health Jacket did indeed reveal normal hearing on a previous annual hearing test. The physical examination was normal except for a severe sensory-neural hypacusia in the left ear of 75 decibels. The patient was admitted and treated as outlined. Hearing started to return in 4 days and at the end of 6 weeks his audiogram was at normal levels except for loss at 4,000 and 8,000 cycles per second.

CASE #2

A thirty-six-year-old pilot with 14 years of active duty awoke on 8 Jan 1964 with "roaring" in his right ear and a severe hearing loss. Previous flight physical examination revealed normal hearing. He was seen at his dispensary and was treated for eustachian tube blockage. When this was not successful, he was referred to Tripler General Hospital one week later where the physical examination was normal except for 80 decibel sensory-neural hypacusia. He was admitted immediately and treated as outlined. On 18 Jan, the patient had 20 decibel loss and, on 21 Jan, after treatment for 6 days, his hearing was normal.

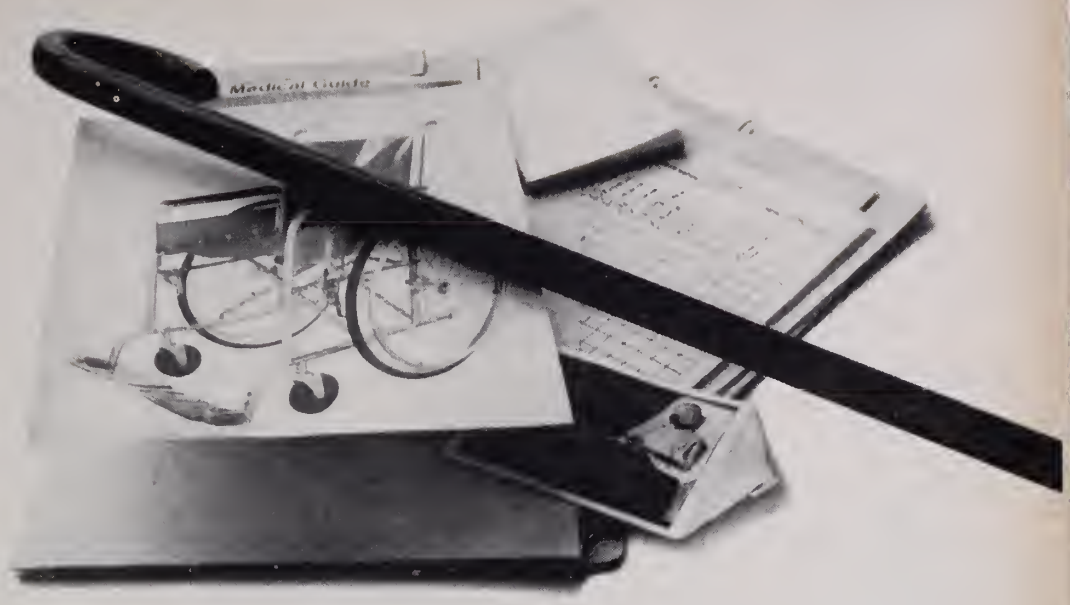
CASE #3

A fifty-two-year-old merchant seaman had onset of sudden deafness in his right ear 8 months prior to being seen at Tripler General Hospital. The patient had received no previous treatment and, in spite of the fact that no relief was expected, it was decided to give the patient the benefit of therapy. Admission audiogram revealed 50 decibel sensory-neural hypacusia. After intensive vasodilating therapy, 6 days later, audiogram revealed a hearing loss of 40 decibels, which is within the range of testing error.

CASE #4

A forty-year-old soldier was seen on routine physical examination for retirement. Audiogram revealed severe, unilateral hearing loss and history revealed that this was of the sudden type and occurred 10 months previously. No treatment was instituted.

(Continued on page 538)



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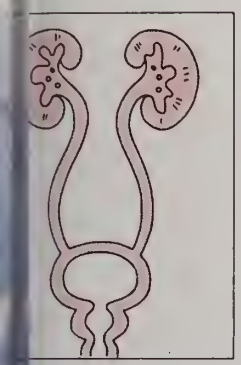
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1. Peters, J. H.: *J. Urol.*, 87:747, 1962. 2. Draper, J. W., *et al.*: *South. M. J.*, 57:920, 1964. 3. Stewart, B. L.: *J. Urol.*, 87:491, 1962. 4. Hagstrom, R. S.: *Rocky Mountain M. J.*, 59:(2), 37, 1962. 5. Arnold, J. H.: *Clin. Med.*, 71:552, 1964. 6. Nelson, C. G.: *Colorado GP*, 3:(3), 2, 1961.

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re prescribing, please consult complete product mation, a summary of which follows:

raindicated in sulfonamide-sensitive patients, hant females at term, premature infants, or newinfants during first three months of life.

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autions: Observe usual sulfonamide therapy pre- ons, including maintenance of an adequate fluid e. Use with caution in patients with histories of ies and/or asthma. Patients with impaired renal ion should be followed closely since renal impair- may cause excessive drug accumulation. Occa- l failures may occur due to resistant microorgan- Not effective in virus or rickettsial infections.

rse Reactions: Headache, nausea, vomiting, urti- , diarrhea, hepatitis, pancreatitis, blood dyscra- neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

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Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

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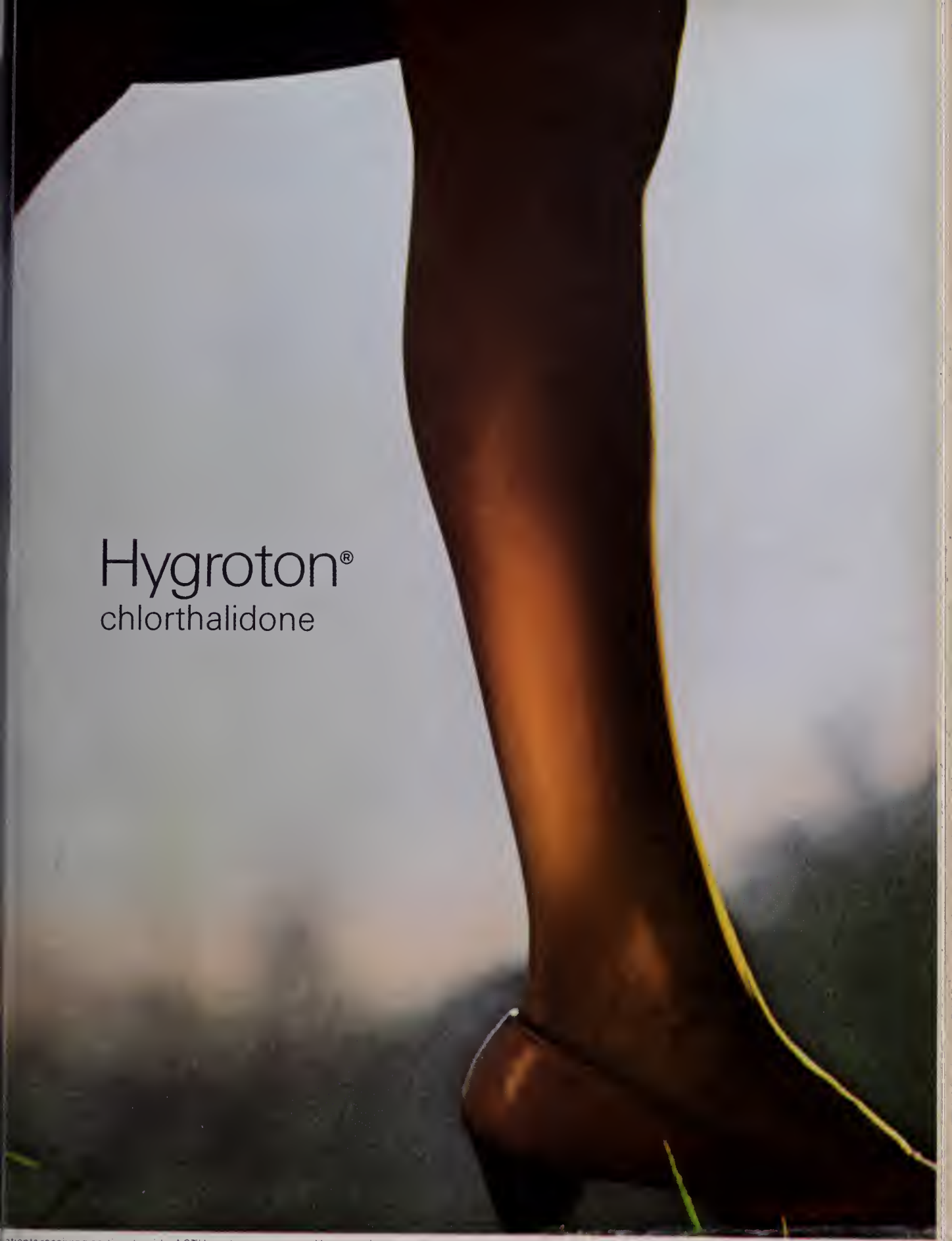
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See preceding pages for brief summary of prescribing information.



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SPECIAL ARTICLES

One Hundred Years Later†

KENNETH P. CRAWFORD, M.D.*

IN many respects it seems unusual that in 1967 we must still emphasize the need for immunization. From the observation of Jenner that maids recovered from cow pox were immune to small pox a steady, if at times slow, development has been achieved in the area of immunization.

This year marks the 100th anniversary of Lister's first publication on antisepsis. Advances made in these 100 years far outweigh all advances made in medicine since the beginning of time. The determination of the etiology of infections and the many controlling measures have made possible the fantastic advances we today consider an every-day part of modern medicine.

In the lifetime of all physicians today has come the control of poliomyelitis by immunization, first through Salk vaccine and now primarily with Sabin vaccine. From a high incidence of 21,000 reported cases in 1952, polio has dropped to less than 100 cases in the U.S. in 1966, and of these over 70 were in Texas areas near the Mexican border where both poor immunization and out of country contacts were factors.

Likewise reduction of reported diphtheria cases has fallen from 18,675 in 1945 to 160 in 1965. This has been possible only as a result of increasing success in mass immunization through private and public health channels.

Data from the 1965 United States Immunization Survey show that noticeable progress has taken place since 1962, when the vaccination assistance act was passed. There has been an increase from 68% to 74% in the number of children one through four years of age who have received three or more D.P.T. innoculations. This represents an increase of about one million preschool children protected. It is reassuring to note that more and more children under one year of age are being protected.

The newest area of immunization protection is for common measles. Prior to the development of an adequate preventive, physicians were reluctant to speak of the complications of this childhood disease. However, it is known that approximately one of every 1000 cases resulted in encephalitis, frequently with severe permanent disabilities, mental retardation, deafness, and blindness. Until the measles vaccine was introduced in 1963 between 400 and 500 children died each year because of measles and its complications. The effect of the vaccine was first noted in 1965 when the number of cases dropped below any recent annual number. The incidence in 1966 hit a 21 year low as a result of immunization efforts of private physicians and public health programs. In spite of this more than 150 cases of measles encephalitis and 250 deaths from measles were reported in 1966.

If the remaining "several million" children unprotected from measles are vaccinated before the spring measles season, 1967 can be the year the United States wipes out common measles, according to William H. Stewart, M.D., U.S. Surgeon General. More than 15 million children have been protected against this potentially dangerous disease. Still 1966 saw 3.7 million babies born that will need immunization when they reach their first birthday according to his report.

In 1966 measles vaccine became available through the vaccination assistance act. Eighty per cent of preschool children in the United States are now eligible for vaccine under this act of Congress. And since several epidemiological studies of measles epidemics have provided data on the importance of young school children in the transmission of measles outbreaks, additional emphasis must be placed on vaccination of this important group.

Recommendations for the widest possible measles immunization have been made by the American Medical Association, the U.S. Public Health Service and the American Academy of Pediatrics, to name a few.

(Continued on page 529)

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†The Journal asked that this Special Article be written in order to give emphasis to Kentucky Immunization Week which was held May 1-6. The article points out the remarkable achievements in the past 100 years in this area of preventive medicine. It gives emphasis to the present need for measles vaccination and it indicates some important new vaccines which may become available in the future.

**Assistant clinical professor of pediatrics at the University of Louisville School of Medicine and an active member of numerous medical and civic organizations.*

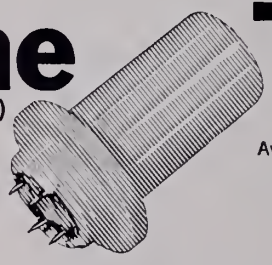
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EDITORIALS

Hail The Parks

AT this time of year many Kentuckians, including KMA members and their families, will be making plans to take vacations in Kentucky state parks.

It is difficult to make any exact measurement of the benefit of a fishing or camping trip to a man's health. However, physicians soon come to appreciate that such recreational ventures are essential to most men if they are to enjoy a feeling of well-being and are to function at their best. There are good reasons to believe that people are benefited not only psychologically by certain vacations but their physical health may also be improved.

It is for this reason that the medical profession has a special interest in the recreational and park facilities that exist in the state. Physicians themselves have experienced the added zest they have for their work after returning from a vacation of some type. From a medical standpoint we may speculate why this is so.

Not necessarily in order of their importance, the following benefits may be derived from a vacation. There is that calming and relaxing effect on the human spirit known to the poets of forests, mountains and expanses of water. There is the opportunity to flex and use large skeletal muscles that are seldom called upon in the usual sedentary occupations; this alone often relaxes and relieves accumulated tensions. There is the opportunity to escape the day by day decision-making; a chance to get away at least temporarily from some of the irritations of the job.

Considering the two ever-growing factors of increasing population and urbanization, it has become a challenge to find a lake or mountain that isn't littered with old tires, junked cars and beer cans. Fortunately among us there have been those men in the past and in the present who laid the plans for our present outstanding Kentucky State Park Program and who now continue to carry out the development of these parks.

Aside from the contribution to the health of Kentuckians that the state parks make, the economic gain from the parks is impressive. In 1966 Kentucky's 35 parks and shrines attracted 16,127,865 visitors. The gross receipt exceeded $5,000,000. The whole Kentucky tourist industry is increasingly profitable. All travelers spent $425 million in Kentucky last year. Tourist spending for 1966 showed a gain of 13% over 1965.

New job opportunities and new payrolls are products of the increasing tourist business. Private business and the state and local government gain from the travel business. The travel business makes a significant contribution to the revenue of state and local governments. A recent report indicated that $182 million was collected from the travel business from various taxes during the last fiscal year.

This tax money helps to support the health responsibilities of government as well as other aspects of government function. The state parks and shrines are key attractions for this steadily increasing number of tourists and vacationers.

Kentucky physicians appreciate the value of the state parks and will continue to have a special interest in their development.

WALTER S. COE, M.D.

The Ohio Valley Regional Medical Program

ON October 6, 1965 the 89th Congress passed public law 89-239, entitled "An Act to Amend the Public Health Service Act to Assist in Combating Heart Disease, Cancer, Stroke, and Related Diseases." The avowed purposes of this Act were "(a) Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke and related diseases; (b) To afford to the medical profession and the medical institutions of the nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and (c) By these means to improve generally the health manpower and facilities available to the nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

The law authorized the appropriation of $50 million in fiscal 1966, $90 million in fiscal 1967, and $200 million in fiscal 1968, with the aim that the majority of this money was to be spent in planning and pilot projects among the various regions. The law specifically states that appropriated funds will not be available to pay the cost of hospital, medical or other care of patients except if such care is incident to research, training, or other similar activities.

With the aid and encouragement of the Public Health Service, under the Department of Health, Education and Welfare, and operating specifically from a "Division of Regional Medical Programs" established at the National Institutes of Health, some 50 or more separate regions have submitted applications for, or indeed have already received, planning grants under this legislation. These regions are, both in their organization and geography, quite flexible, but many regions seem mainly to be concerned with single states, or seem to be centered around a single medical school as the hub of the medical area involved.

The Ohio Valley Regional Medical Program formally commenced activities January 1, 1967, with the acceptance of a grant somewhat in excess of half a million dollars for its initial two-year planning phase. The background work, and the initial organization under this program, have been thorough and careful, and, as a result of a good deal of searching preliminary thought, the region in this program encompasses the sphere of influence of three medical schools—the University of Kentucky, the University of Cincinnati, and the University of Louisville. The region broadly includes 101 Kentucky counties, 21 Indiana counties, 14 Ohio counties, and 2 West Virginia counties, with a 1962 population of more than 5.75 million persons. Cooperation, and interchange of information between and among the various participants in this broad area, will be hopefully one of the keynotes of the program, and quite possibly one of the major advantages to accrue therefrom. Administratively, the Executive Board consists of the Chairman, Louis Wozar—a recognized civic leader from Dayton, Ohio; the Vice Chairman, Mrs. Rexford Blazer—also of course known for her wide range of civic interests, from Ashland, Kentucky; Vice President William Willard, M.D., from the University of Kentucky; Dean Clifford Grulee, M.D., of the College of Medicine, University of Cincinnati; and Dean Donn Smith, M.D., School of Medicine, University of Louisville. The chief member of the full time staff of this organization occupies the position of Director, and we are fortunate to have William McBeath, M.D., in this position. An Advisory Council consisting

of interested lay personnel and physicians, and numbering 36 in all, has been established, and has held its first meeting, in Cincinnati on February 21 and 22 of this year. There was, also, a meeting of approximately 600 people interested in this program, in Washington, D.C., January 15 through 17 of this year.

It seems quite likely that any program with so much tax money, and so many capable people behind it, is likely to accomplish something! As yet, however, exactly what its detailed objectives will be is not clear—the preliminary emphasis seems possibly to be directed toward continuing medical education, both for medical and para-medical personnel, but this will certainly be only one of the eventual goals. There is, thus far at least, very little evidence that this is to be a program entirely directed from the Federal Government; every emphasis so far seems to be toward the development of unique and individually applicable regional plans. Certainly the prevalent feeling at the moment among the 13 physicians on our Advisory Council seems to be that the program should be devised to support, encourage, and assist those in private practice, to enable them to offer their patients the best of modern medical care. In short, while it is probably fair to say that most of those to whom this Journal is addressed very seriously question the necessity of the expenditure of this type of Federal money, since it is indeed to be done, it is important that the Program make the best possible use of the funds. It is also important that we all are aware of this Program; and constructive criticisms, or suggestions, will be welcomed by the Director, and by the Council.

WALTER I. HUME, JR., M.D.

Make Plans Now

to attend the

KMA Annual Meeting

September 26-28

Convention Center **Louisville**

ORGANIZATION SECTION

Transatlantic Panel to be Feature of 1967 KMA Annual Meeting

Four distinguished members of the Royal Commonwealth of the Postgraduate Institute of England and four KMA members will participate in a one-hour trans-Atlantic panel discussion of "Gastrointestinal Bleeding" during the 1967 Annual Meeting of the Kentucky Medical Association. The meeting will take place September 26 through 28 at the Louisville Convention Center with headquarters at the Kentucky Hotel.

The themes of the 1967 meeting will be "Trauma," "Allergy," "Organ Transplants—Present and Future," "Therapeutic Abortions," and "Birth Control." A "What's New Symposium" will consist of a series of brief, informative discussions by various specialists of the new developments in their fields.

Sixteen specialty groups will hold sessions on the afternoons of September 26 and 28. The transatlantic panel discussion is scheduled for the afternoon of September 27.

James F. Glenn, M.D., Durham, N.C., guest of the Kentucky Urological Society will appear on the scientific program September 26. His topic will be "Genitourinary Trauma." Doctor Glenn is a professor of urology at Duke University where he received his medical degree in 1952. He was formerly associated with the medical schools of Yale University and Wake Forest College.

Doctor Glenn is a member of the American Association of Genitourinary Surgeons, American Board of Urology, American College of Surgeons and many other professional societies. He has published more than 80 scientific articles and a number of motion pictures related to his field.

Also appearing on the scientific program September 26 will be Peter Safar, M.D., Pittsburgh, Pa., guest of the Kentucky Society of Anesthesiologists. He will discuss "Oxygen Delivery in Shock." Doctor Safar, who has been professor and chairman of the department of anesthesiology at the University of Pittsburgh School of Medicine since 1961, received his medical degree from the University of Vienna in 1948.

He served as chief of the department of anesthesiology of the National Cancer Institute in Lima where he founded Peru's first residency of anesthesiology. Doctor Safar holds membership in numerous professional societies including the American Society of Anesthesiologists, the Pan Am Medical Association, the Association of University Anesthetists and the American Heart Association.



Doctor Glenn



Doctor Safar

Additional program information will be released as it becomes available.

KEMPAC Board of Directors Elected by KMA Trustees

The Board of Trustees of KMA at its April 19 meeting elected the members of the Board of Directors of the Kentucky Educational Medical Political Action Committee. Officers of the new Board were to be chosen May 3.

According to Rex E. Hayes, M.D., chairman of the KMA Board, members of the KEMPAC Board are elected by the KMA interim governing body to serve for a period of one year.

The following board members were elected: 1st Congressional District, James Cox, M.D., Hopkinsville, and John Quertermous, M.D., Murray; 2nd, Fred Rainey, M.D., Elizabethtown, and Reginald Phillips, M.D., Owensboro; 3rd, Cecil Grumbles, M.D., and William Sandman, M.D., both of Louisville; 4th, Carl Cooper, M.D., Bedford, and Kenneth Peters, M.D., Jeffersontown; 5th, William Wyatt, M.D., Somerset, and Meredith Evans, M.D., Middlesboro; 6th, David Stevens, M.D., Lexington, and John Stewart, M.D., Frankfort; 7th, Keith Martin, M.D., Ashland, and Jerry Fraim, M.D., Paintsville.

Representing the Woman's Auxiilary will be Mrs. Arthur S. Holmes, Corbin, Mrs. Charles Kessinger, Henderson, and Mrs. Clyde Sparks, Ashland.

Due to the time of the month that the 1967 KMA Interim Meeting was held, it was not possible to carry information in this Journal. Pictures and details will be included in the June issue.

Two Nashville Surgeons To Speak To Ky. Surg. Soc. May 19-20

Two prominent Nashville surgeons will be guest speakers at the 18th Annual Session of the Kentucky Surgical Society May 19 and 20, according to Blaine Lewis, M.D., Louisville, Society secretary. The meeting will be held at Park Mammoth Resort in Park City.



Doctor Byrd

Benjamin F. Byrd, Jr., M.D., chief of surgical services at St. Thomas Hospital and former instructor at Vanderbilt University School of Medicine, will speak at the Society's Saturday morning session May 20. Doctor Byrd graduated from the Vanderbilt University School of Medicine in 1941. He is president-elect of the Southeastern Surgical Congress and president of the Tennessee Division of the American Cancer Society. He holds membership in many professional societies and has published a number of scientific articles.

Barton McSwain, M.D., professor of surgery at Vanderbilt University, will address the group on Friday morning, May 19. Doctor McSwain graduated from the Vanderbilt University School of Medicine in 1930. He is a member of the Nashville Academy of Medicine, the American College of Surgeons, the American and Southern Surgical Associations, and many other professional societies. He has made numerous contributions to medical literature.



Doctor McSwain

Immunization Week Held In Kentucky May 1-6

Governor Edward T. Breathitt joined the Kentucky Medical Association and other state organizations in urging Kentuckians to check the immunization records of their families by proclaiming May 1-6 as State Immunization Week. The purpose of Immunization Week was an attempt to achieve complete immunization in the state against smallpox, polio, diphtheria, pertussis, tetanus, typhoid fever, and measles.

Appreciation was expressed recently to KMA members for their participation in Immunization Week by Walter L. O'Nan, M.D., Henderson, chairman of the KMA Public, Rural and Occupational Health Committee.

Doctor O'Nan urges KMA members to keep a check on the immunization records of their patients, especially children, stressing that the continued success of this program depends on physicians.



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4th Trustee District To Meet May 24 in Lebanon

Physicians and their wives attending the Fourth KMA Trustee District Meeting Wednesday, May 24, will hear an address by KMA President Robert E. Pennington, M.D., London, according to Henry S. Spalding, M.D., Bardstown, trustee for the district.

The Marion County Medical Society will host the meeting which will be held at Prosino's Restaurant in Lebanon.

Douglas David, M.D., Louisville, will also appear on the program. His topic will be "The Modern Concepts of Antibiotic Treatment of Respiratory Diseases."

7th Trustee District Meeting Set May 25 in Frankfort

The Seventh KMA Trustee District will hold its annual meeting the evening of May 25 at the Statesman in Frankfort on U.S. 60 near the Georgetown Pike, according to Donald Chatham, M.D., Shelbyville, trustee for the district.

Robert E. Pennington, M.D., London, KMA president, will be the featured speaker at the meeting. He will share the program with guest speaker Rudolf J. Noer, M.D., professor and chairman of the department of surgery at the University of Louisville.

Fred Rainey, M.D., Elizabethtown, will speak briefly on the activities of KEMPAC. The session will be a joint meeting with the Franklin County Medical Society.

Program Outlined for June 10 Emergency Room Conference

"Facts and Figures on Emergency Rooms" will be the topic of a talk by Richard E. Manegold, M.D., Chicago, at the morning session of a conference on "The Hospital Emergency Room 1967: Problems and Proposals" at 9 a.m., June 10, at Stouffer's Inn, Louisville. Doctor Manegold is director of the Department of Hospitals and Medical Facilities of the American Medical Association.

Spencer T. Snedecor, M.D., Hackensack, N.J., chairman of the Subcommittee on Emergency Room Standards of the Committee on Trauma, American College of Surgeons, will speak on "Quality Patient Care." KMA, the Kentucky Hospital Association and the Trauma Committee, Kentucky Chapter, American College of Surgeons are sponsoring the one-day conference.

The afternoon session will feature a discussion on "A New Look at Emergency Care" by Kenneth Eblen, M.D., Henderson, Edward W. Horgen, Ashland, and John C. Pratt, Lexington. "Code 500" will be presented by Branham B. Baughman, M.D., chairman of the Kentucky State Board of Health, and Harry Jobe and Margaret Poindexter, R.N., of King's Daughters Hospital, Frankfort.

KMA members planning to attend should forward a $5.00 pre-registration fee to the KMA Headquarters Office.

Tandearil®
oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

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Tandearil® oxyphenbutazone helps painful shoulders move again



3 out of 4 painful shoulder patients responded well

84.2% of 127 patients

81% of 48 patients

Please see adjoining page for brief prescribing summary.

TA-5094PC

Sperling, I L. Applied Therap. 6 117, 1964
Rosenbaum, E. E., and Schwarz, G. R. Northwest Med. 61:927, 1962

Why these 7 patients with moderate to severe anxiety may respond better to Mellari



1. The agitated patient.
Anxiety—particularly that beyond th range of minor tranquilizers—fre quently is expressed as gross moto restlessness, fidgetiness and purpos less movements, and may erupt int aggressive behavior. Mellaril is a most a specific for those patient whose anxiety follows such a patter



The psychosomatic patient.

family physician is rarely given iagnostic luxury of a classic, ook "anxiety state." Most often st probe for anxiety masked by tional disorder—or which exacs a somatic problem. Double- evaluations have demonstrated Mellaril can be a significant adin the treatment of such patients.



The patient under tional stress.

il helps the patient deal with s of everyday life. Nonhabitu- it can be given for extended pe- of time. It does not "separate" tient from practical problems ressures, does not induce eupho- a fuzziness which can compro- the ability to cope with reali- s. Rather, it helps the patient ove more competently in his daily world by eliminating use- less tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

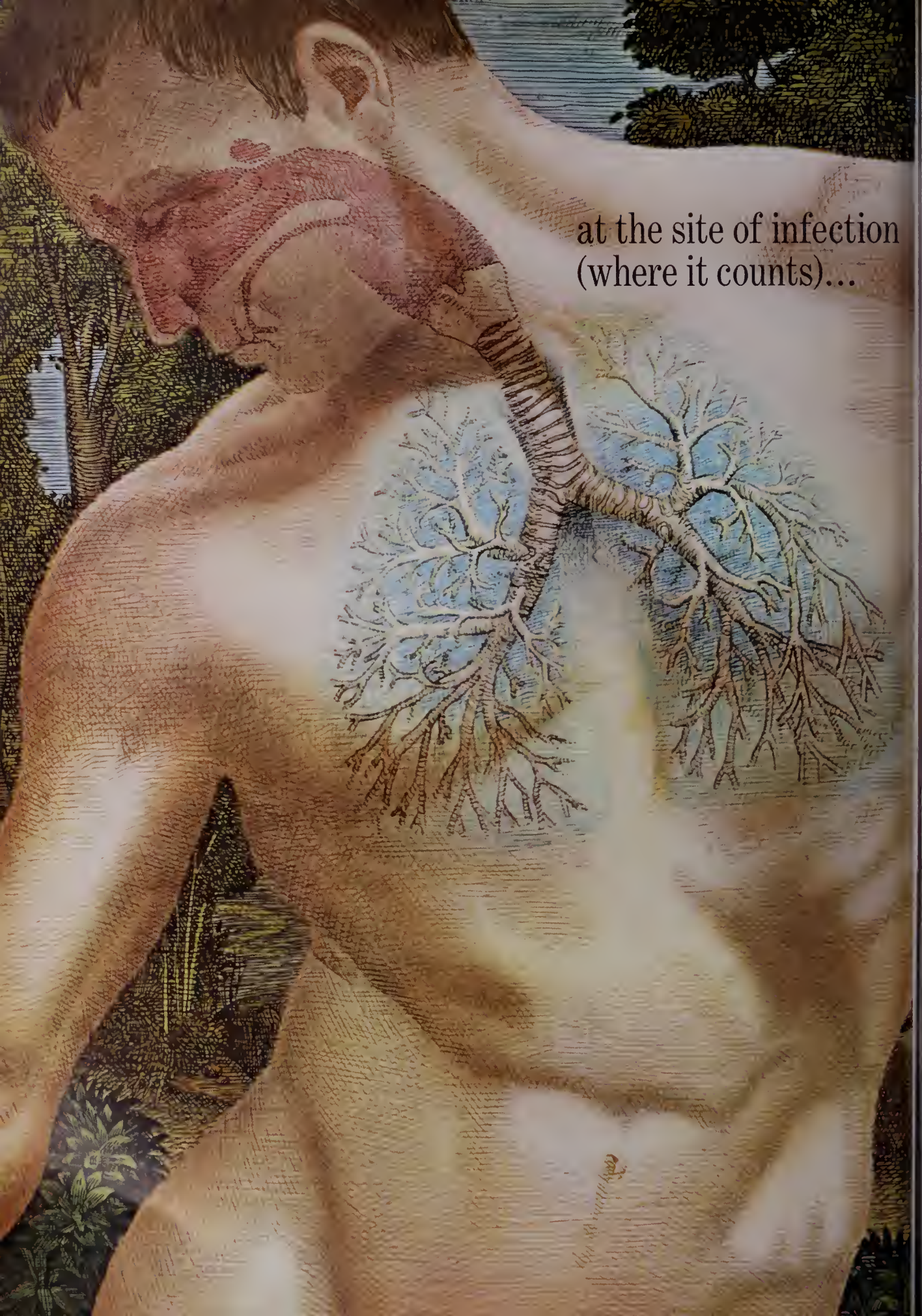
The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®

Lilly

Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, an mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six month patients with rheumatic fever have taken prophylactic do 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had epi of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mont rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Ele of SGPT and serum alkaline phosphatase levels during the of treatment was observed in one patient treated with I and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the pen group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients were parable to those in a similar control group who had re penicillin.

Gastro-intestinal disturbances not associated with hepa fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with t of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds o weight, the usual dosage is 5 mg. per pound every six hou children twenty-five to fifty pounds, 125 mg. every six (Tablets Ilosone Chewable should be chewed or crushe swallowed with water.)

For adults and for children over fifty pounds, the usual of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythr therapy should be considered.

In the treatment of syphilis, the recommended total do 20 to 30 Gm. given in divided doses for a period of ten to days. Close follow-up of the patient is necessary since er mycin drugs have not had adequate evaluation in all sta syphilis. Examinations of spinal fluid are recommended a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four da recommended. In the treatment of gonorrhea, patients suspected lesion of syphilis should have a dark-field exami before receiving antibiotics, and monthly serologic tests be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 2 (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equi to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pac

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:6
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:39
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.



Hoyt Gardner, M.D., left, president of the Jefferson County Medical Society, and Robert Pennington, M.D., far right, president of the Kentucky Medical Association, welcome Doctor Tom Haggai, nationally famous minister and speaker from High Point, North Carolina, to KMA Senior Day March 20 in Louisville. Doctor Haggai spoke on "How to Get What You Want" at the Thirteenth Annual Senior Day sponsored by KMA in close cooperation with the U of L School of Medicine and the Jefferson County Medical Society.

U of L Alumni Reunions Planned During KMA Annual Meeting

Plans are being made for alumni reunions of the five-year classes of the University of Louisville School of Medicine during the KMA Annual Meeting September 26 to 28, according to Les Shively of the U of L Alumni Office. Features of the reunions include a tour of the Medical Center and a ride on the Belle of Louisville September 26.

Chairmen of the classes holding reunions selected thus far are as follows (all are in Louisville with the exception of the class of 1942):

1922—E. W. Akins, 2706 Grinstead Dr., 896-4393

1927—R. O. Joplin, Medical Arts Bldg., 458-3325

1932—C. F. Blankenship, M.D., 3002 Falmouth Dr., 454-7289

1937—Charles C. Bryant, M.D., Medical Arts Bldg., 452-1558

1942 (the 25-year class)—Charles Rutledge, M.D., Hazard, 436-3121

1947—Ed Warrick, M.D., 211 Travois Rd., 895-3126

1952—Burton Heine, M.D., Medical Arts Bldg., 458-6462

1957—Stanley Collis, M.D., Medical Towers, 583-5015

1962—Randall Moore, 1037 Everett, 459-1374

Dr. Massie Honored by UK

Francis M. Massie, M.D., Lexington, was awarded an honorary doctor of science degree by the University of Kentucky, where he is a clinical professor of surgery, at its May 8 commencement. Doctor Massie, recipient of the KMA Distinguished Service Award in 1959, was an instrumental force in the establishment of the University's Medical Center.

Ky. Dentists Choose Dr. Kranz President-Elect for 1967

William C. Kranz, D.M.D., a Lexington oral surgeon, was named president-elect of the Kentucky Dental Association at its 107th annual convention April 4 in Louisville. Pat H. Lyddan, D.D.S., Louisville, took office as president.



Doctor Kranz

Vice-presidents-elect chosen at the meeting were James E. Skaggs, D.M.D., and Harry Gilmore, D.M.D., both of Louisville. William A. Garrett, D.D.S., Atlanta, president of the American Dental Association, spoke to the group about the ADA's national dental health program for children.

Doctor Kranz graduated from the University of Louisville School of Dentistry in 1951. He is president of the Kentucky Society of Oral Surgeons, a past president of the Blue Grass Dental Society, and a member of the American and Southeastern Societies of Oral Surgeons.



More than 200 persons attended the fourth annual Senior Day Program at Lexington, April 11, at which Milford O. Rouse, M.D., Dallas, president-elect of the American Medical Association, spoke on "Professional Citizenship." Pictured at the program's evening session from left to right are John F. Berry, Jr., M.D., president of the Fayette County Medical Society, Ray Jacobsen, senior class president, Doctor Rouse, Robert E. Pennington, M.D., KMA president, who spoke to the group on "What Can Organized Medicine Do for Me?" and Tom F. Whayne, M.D., dean of the UK Medical Center. The program was sponsored by KMA in close cooperation with the UK Medical Center and the Fayette County Medical Society.

Correction

The Journal of the Kentucky Medical Association regrets a typographical error which appeared on page 374 of the April issue. In the second line of the second paragraph of the article "Epithelial Papilloma of the Nasal Cavity," the correct year is 1964 rather than 1954 as printed.

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Twenty-nine Physicians Added To KMA Membership

The following 29 physicians have become members of the Kentucky Medical Association according to the records of the membership department as of April 20:

Franklin K. Belhasen, M.D., Paintsville; Curtis E. Bippert, M.D., Paducah; John P. Blackerby, M.D., Bowling Green; T. Fenton Burke, M.D., Hopkinsville; John Fielding, M.D., Warsaw; Jose Fleites, M.D., Ashland; Ronald M. Garvin, M.D., Valley Station; E. K. Hand, M.D., Vine Grove; Charles R. Harris, M.D., Berea; Donald Hartman, M.D., Madisonville; Robert H. Hyde, M.D., Eddyville; B. J. Jackson, M.D., Lawrenceburg; and Harold L. Johnson, M.D., Frankfort.

H. Myron Kauffman, Jr., M.D., Lexington; Richard F. Keeler, M.D., Whitesburg; James G. Kuhns, M.D., Louisville; Antonio U. Lira, M.D., Covington; Sidney G. Marcum, M.D., Louisville; Karl M. Neudorfer, M.D., Ashland; Joe Amos Nichols, M.D., Cynthiana; Frank Pitzer, M.D., Hopkinsville; James J. Rams, M.D., Lexington; C. William Rogers, M.D., Madisonville; John R. Sanders, M.D., Owensboro; Marilyn M. Sanders, M.D., Owensboro; William P. Stone, M.D., Bowling Green; Louis A. Vasquez, M.D., Louisville; Raymond Wells, M.D., Inez; and Mary L. Wiss, M.D., Hyden.

George Grider Becomes APA Pres.

George Grider, a Danville, Kentucky, pharmacist, was instituted as president of the American Pharmaceutical Association at its recent Las Vegas meeting. Mr. Grider is a member of the McDowell Board of Governors and has long been active in his profession in this state.

Ft. Thomas VA Hospital To Be Converted to Nursing Home

The Veterans Administration Hospital at Ft. Thomas, a division of the Cincinnati VA Hospital, will be converted into a nursing home by the end of this year, according to the Information Service of the Veterans Administration.

"We expect this will be a model nursing home for VA patients," said Lorenzo H. Gunter, Ft. Thomas, director of the Cincinnati VA Hospital. Plans include rooms for dining, recreation, patient activity and physical therapy, which will be furnished in a home-like atmosphere.

Patients for the home will come from nearby VA hospitals. They will be older veterans who do not require the constant services of a physician but are in need of skilled nursing care. The doctors have noted that the patients are looking forward to moving from the hospitals to the home.

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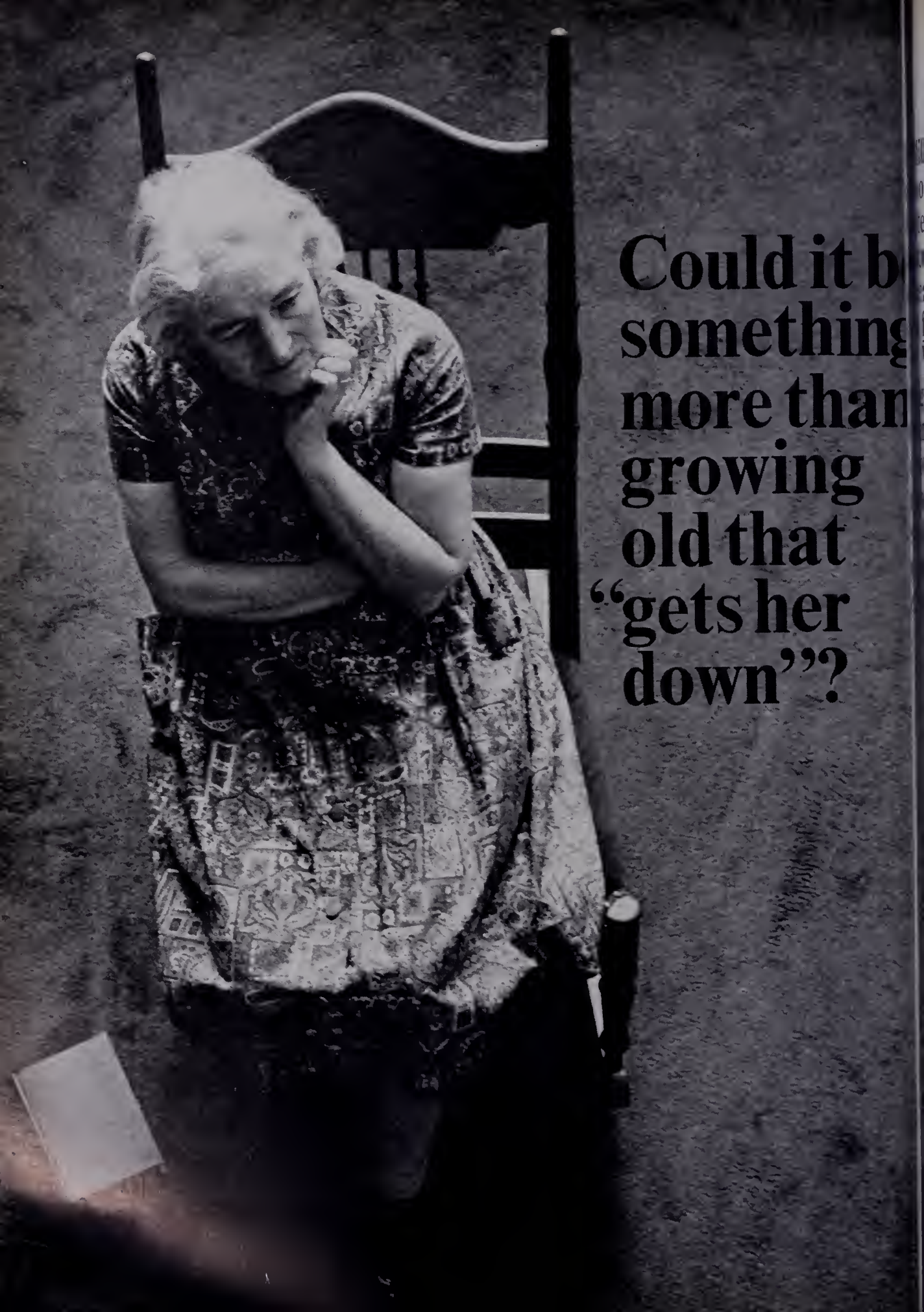
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Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

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Mrs. Peggy Roberts Joins KMA Journal Staff

Mrs. Peggy Roberts, Louisville, a 1961 graduate of the University of Kentucky, joined the staff of the KMA Journal as assistant managing editor in March. Mrs. Roberts majored in English and journalism and served as associate editor of the Kernel, the UK newspaper, during the summer of 1961.

She was sales and promotion manager for the University of Kentucky Press for three years and served as vice-president of the Lexington alumnae chapter of Theta Sigma Phi, women's journalism honorary society, during 1963 and 1964.

Mrs. Roberts recently returned to Louisville from Chicago where she was office manager for Systems For Education, Inc., a school textbook publishing company specializing in early learning materials.

ARH Takes Over Operation Of Mount Mary Hospital

The Appalachian Regional Hospitals took over the operation of Mount Mary Hospital in Hazard April 1. The merger was a step toward establishment of a health facilities complex to serve Perry, Breathitt, Knott, Leslie and a portion of Letcher counties, according to a report from the ARH.

The Benedictine Sisters, who have operated Mount Mary for 20 years, will remain in Hazard to develop a system of home health services in cooperation with ARH, according to Mother Mary Benedict, mother superior of the St. Walburg monastery.

In addition to its 72-bed hospital in Hazard, the ARH operates eight other non-profit community hospitals in Eastern Kentucky, Virginia, and West Virginia.

Five Associate Degree Curricula To Be Offered in Somerset

Somerset Community College will offer Associate Degree (two year) programs in five allied health disciplines this fall, according to Joseph Hamburg, M.D., and Ellis Hartford, Ed.D., deans at the University of Kentucky Medical Center.

The University's Community College System, Medical Center, and School of Allied Health Professions established the proposed programs. The Administrative Medical Assistant curriculum will prepare students to be medical secretaries and office managers.

The Clinical Medical Assistant curriculum will emphasize clinical skills necessary to assistants of professional persons. The Community Medical Assistant curriculum is designed for auxiliary personnel in community health programs.

Students in the Mental Health Assistant curriculum will train for mental health work, particularly patient and family contact. The Certified Laboratory Assistant curriculum will prepare students for work in clinical laboratories and hospitals.

KMA Announces County Medical Soc. Officers for 1967

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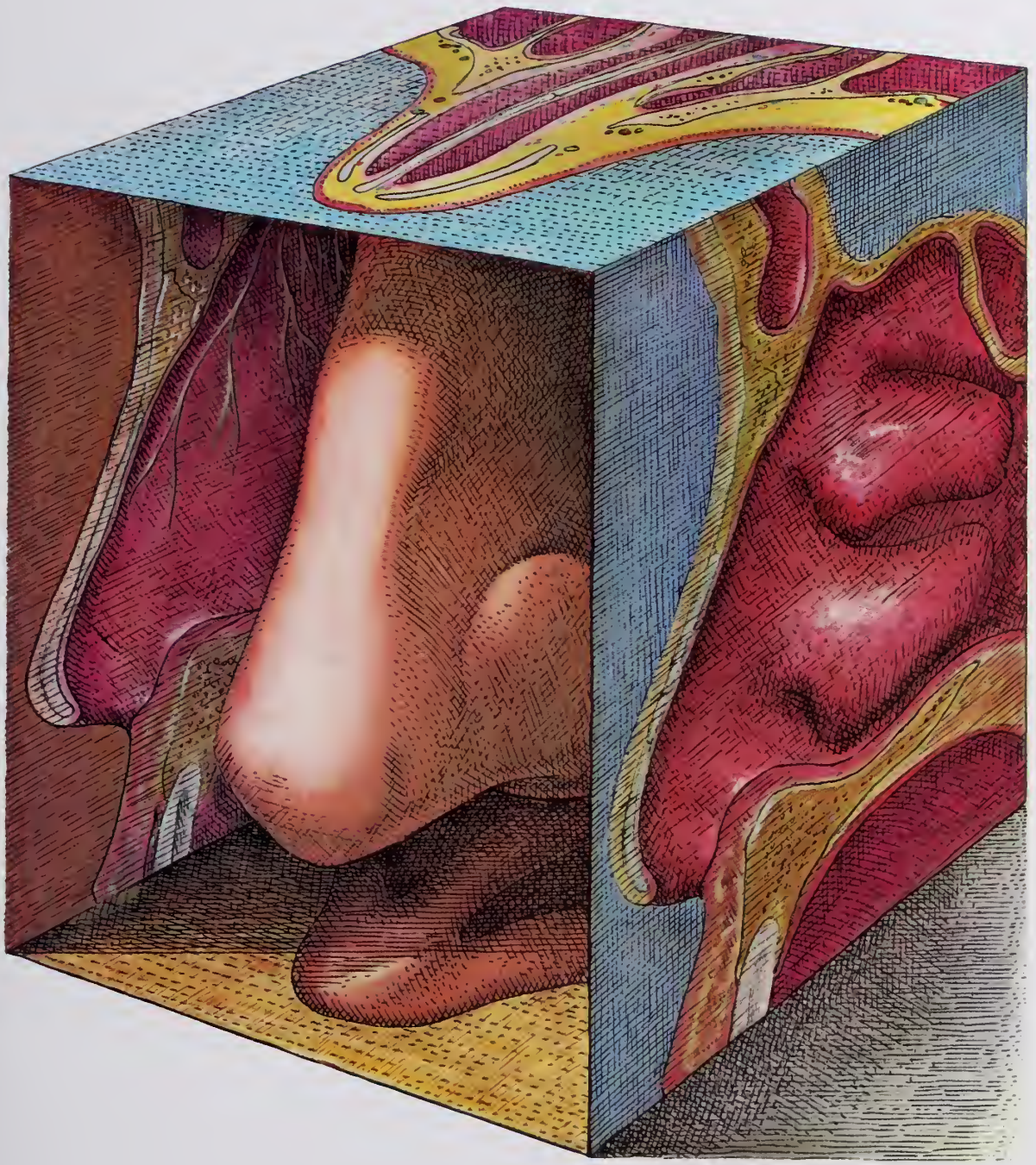
Graves
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(Continued on page 527)

spring 1967

DORSEY Season

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this issue: the ubiquitous world of summer allergies



the ubiquitous world of summer allergies

Donald L. Unger, M.D. • Clinical Assistant Professor, Department of Medicine (Allergy), Stritch School of Medicine (Loyola).

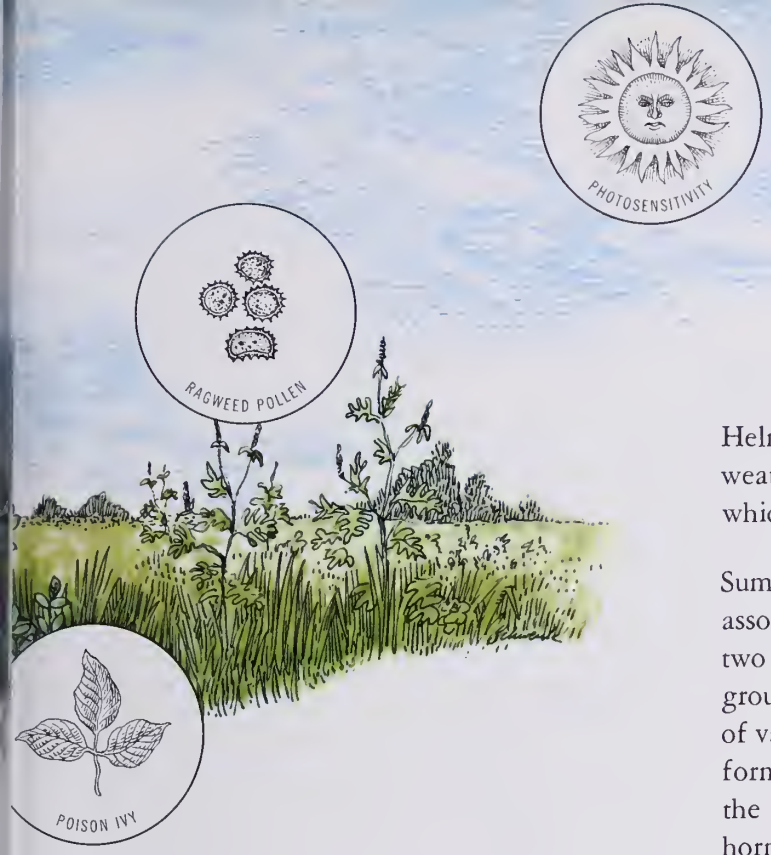
In the Spring a young man's fancy lightly turns to thoughts of—allergies. This is at least true of the 10% of the population who have hay fever and the 4% who have asthma.[1] The snow melts, the trees blossom and the noses run. Patients who were fine all winter may not be enthralled by the sight of the first robin or the blossoming of a crocus, for their appearances may precede the "sneezin' season."

Allergies in general can be divided into winter allergies and summer allergies. In the winter the main problems are inside the house: e.g. dogs, cats, dust and feathers. Houses in the northern half of the country become so dry that it becomes essential to add humidity to the home; this is a far cry from the damp summer months with the moldy basements and need for dehumidifiers.

Early in April trees begin to pollinate, with each tree having about a two week period of pollination. A particular patient may be sensitive to only one tree and thus have his hay fever for such a short time that he thinks he has a cold.[2] The entire tree season starts about April 1 and ends about Memorial Day, although all hay fever seasons are blurred and prolonged in the southern part of the country. Tree pollen is usually very heavy and a person may well have most of his exposure from those trees immediately surrounding his home.

Grasses pollinate from about May 15 until July 4, and cause "rose fever." Grass pollens are somewhat lighter and more buoyant than tree pollens, and are much more ubiquitous. While there are several varieties of grasses in the United States, they are so closely related antigenically that a person sensitive to one is generally sensitive to them all.[3] Thus, while the tree season is really several small seasons intertwined, the grass season will usually result in symptoms for a more prolonged period. Obviously, a grass-sensitive patient will have trouble only when grass is pollinating—he will have to think of another excuse not to mow the lawn after July 4.

Ragweed is the "Big Daddy" of them all in the eastern two-thirds of the country. Pollination is generally from mid-August until the end of September, with the predicted lower counts and longer seasons



in the southern part of the country. Ragweed is a very light pollen which may be windborne for hundreds of miles. An interesting study was made in New York City, in which 90% or more of the ragweed plants were destroyed in three of the five boroughs; pollen counts done during the season were virtually identical in all five.[4]

Ragweed is, of course, the most common cause of hay fever and is associated with an incredible loss of man hours from work each year. Many is the patient who travels to areas where the pollen count is low, just to avoid having symptoms. There is no ragweed anywhere in the world except the United States and portions of Canada and Mexico.

While molds are present through the year, the most important ones predominate from April until November. An old wives' tale has ragweed ending with the first frost, when actually it ends a good month earlier. It is Alternaria—the kingpin of the molds—that meets a sudden demise with the first frost. Alternaria-sensitive patients are in their glory when there is snow on the ground, and might be ideally suited to man the radar stations in Alaska. In September and October, Alternaria counts are at their highest, perhaps associated with the burning of leaves. Other molds such as Hormodendrum and Helminthosporium are associated with the warmer weather, as opposed to Penicillium and Aspergillus which are household molds.

Summer also means the return of our much maligned associates—bugs. Insects cause allergic symptoms by two methods: the bite or sting of the Hymenoptera group, and the inhalation of particles of the bodies of various insects. Wasp stings are the oldest known form of allergy, as they caused the death of one of the pharaohs in ancient Egypt.[5] Bees, wasps and hornets account for many deaths in this country, and those sensitive to them should carry special treatment kits at all times; a few minutes delay in the administration of epinephrine to such a patient, might be the difference between life and death. Inhalation of particles of insects may cause sneezing and wheezing in a susceptible individual.[6] Both of these forms of insect allergy may be benefitted by hyposensitization.

The insect recognizes no professional bounds. He is as apt to bite the physician as the patient. So this season, beware of bugs. And beware, too, of poison ivy. That pleasant stroll through the woods and underbrush with the Boy Scouts might turn into a

(Concluded on following page)

to relieve summer allergies

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nightmare for the botanically uninitiated in the causes of rhus dermatitis (poison ivy, poison oak and poison sumac). Although you may have been careful, your dog may not have noted that it wasn't clover he jumped through, but poison ivy. His return to your side may give you the rhus dermatitis that you so carefully avoided. That heavenly campfire may be emitting particles of rhus oil to produce an airborne contact dermatitis of the exposed areas of the body.

Another fascinating, but rather infrequent type of summer allergy is physical allergy. Some people sneeze on exposure to sunlight, while others break out in rashes, usually on the exposed parts of the body. These rashes may well follow the administration of various photosensitizing drugs, e.g. demethylchlortetracycline.[7] Another form of physical allergy and one that may be lethal in the summer, is cold allergy. Yes, I mean cold allergy, not heat allergy. The cool dip on a hot day with its consequent sudden chilling of the body, may be the coup de grace for a cold sensitive patient.[8] It is customary to write "heart attack" on the death certificate, even though the victim may have been an 18-year-old boy who looks like a Greek god.

Lest the reader be depressed by this saga of afflictions associated with the warmer months, perhaps he should remember that it is also a time for swimming, baseball, lying in the sun and taking that long-planned vacation. So let's all join in a chorus of "In the Good Old Summertime," as we sneeze, wheeze and scratch. Be careful of your suntan lotion, however; it may cause you a contact dermatitis.

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(*Continued from page 522*)

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Alternate: George R. Bellamy, M.D.

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Owen
President: Maurice Bowling, M.D., Owenton
Secretary: O. A. Cull, M.D., Owenton
Delegate to KMA: O. A. Cull, M.D.
Alternate: Maurice Bowling, M.D.

Dr. McCann Joins Rehab. Center; Mrs. Waldron Receives Awards

Nessan McCann, M.D., a native of Dublin, Ireland, became associate medical director of the Louisville Rehabilitation Center recently, according to Robert P. Smith, M.D., medical director of the Center.

Doctor McCann graduated from the National University of Ireland Medical School in Dublin in 1949 and has worked in hospitals in Iran, West Africa, Toronto, Boston, and New Haven, Connecticut.

Mrs. Hazel Waldron, a teacher at the Center, received the Award of the Governor's Commission on Employment of the Handicapped at a special luncheon on April 6. She was named "Handicapped Individual of the Year" and also received the Handicapped Individual Award of the Louisville Committee for the Handicapped.

Six Medicare Leaflets Printed By U.S. Dept. of Health

To answer frequent questions of Medicare beneficiaries, the U.S. Department of Health, Education, and Welfare has printed six new leaflets available to Kentucky physicians through the Metropolitan Life Insurance Company, Box 928, Lexington, Kentucky 40501. They are

How Much Does Medicare Pay for Outpatient Hospital Services
When You Enter a Hospital—How Does Medicare Help
Medicare and the Extended Care Facility—What It Means to You
Your First $50 Medical Insurance Expenses under Medicare Meets the Calendar Year Deductible
Medical Insurance Claims under Medicare—Methods of Payment
How Medicare Helps to Pay a Home Health Agency for Providing Your Home Health Benefits

P. L. Fuson, M.D., has moved his offices from Middlesboro to Tazewell, Tennessee, according to a recent press report.

42 year old G.P. (A.A.G.P.) desires male associate, age 25-45. Southern California opening July 1, 1967, to associate with G.P. established 14 years, as replacement for well established associate of 11 years leaving for residency. Excellent income with salary guarantee and/or percentage, as desired, and eventual partnership possible. O.B. optional; excellent modern hospital facilities with teaching centers nearby. Modern, well equipped, air conditioned office, with six aides, located in Whittier, Calif. midway between nearby beach, mountain, and desert resorts, all with outstanding recreational facilities. Nearby metropolitan area offers cultural and educational opportunities.

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KMA Council and Committee Reports

Council on Scientific Assembly

Robert E. Pennington, M. D., London, Kentucky, Chairman

KMA Headquarters Office **October 27, 1966**

The KMA Council on Scientific Assembly met soon after the 1966 Annual Meeting to plan next year's Annual Session which is scheduled for September 26-28, 1967.

General plans for all business and scientific activities associated with the Annual Meeting were outlined for 1967, and the details for all scientific sessions were referred to the Scientific Program Committee. Request from allied groups to schedule functions during the 1967 Annual Meeting were considered and times assigned for such activities were made as felt appropriate by the council members.

The 1967 Annual Meeting again will be held at the Convention Center in Louisville with the Kentucky Hotel being the headquarters hotel.

Mental Health Committee (Council on Medical Services)

Logan Gragg, M.D., Lexington, Chairman, Presiding

KMA Headquarters **February 9, 1967**

The development of closer liaison between physicians in psychiatry and general practice was the primary matter considered by the committee members at their second meeting of this associational year.

Hollis Johnson, M.D., and John W. Ambach, M.D., of Louisville, reported on a recent meeting co-sponsored by the American Academy of General Practice and the American Psychiatric Association concerning this same subject.

The committee endorsed and recommended closer coordination between the Kentucky Academy of General Practice and the Kentucky Psychiatric Association.

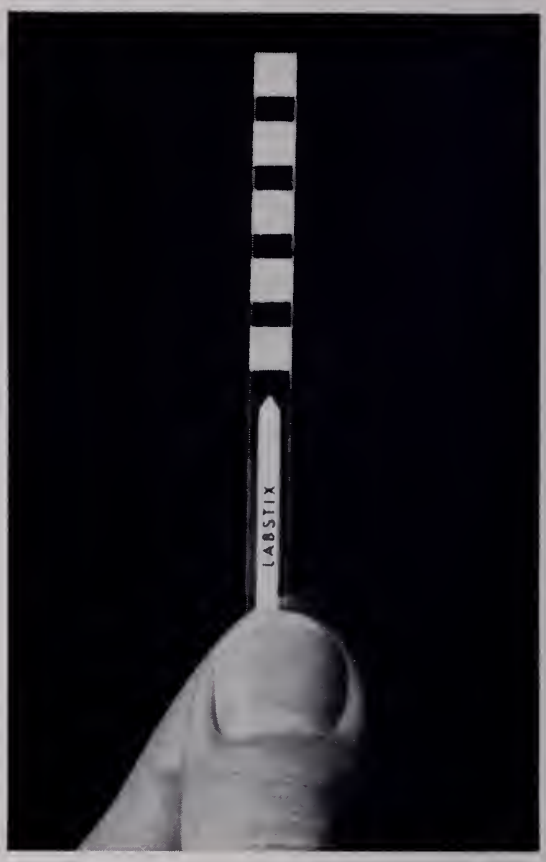
Council on Governmental Medical Services

Paul J. Parks, M.D., Bowling Green, Chairman

KMA Headquarters Office **March 29, 1967**

Reports of the committees serving under the Council were discussed. The chairman expressed appreciation to Garnett Sweeney, M.D., Chairman of the KMA Technical Advisory Committee on Medical Assistance for the new simplified single claim form for use by physicians when the patients are eligible for both Medicare and Medicaid. Terminology corrections have also been made in the Social Security "Explanation of Benefits Form", at the request of the KMA Advisory Committee on Title XVIII.

The chairman reviewed letters that had been written to Kentucky senators and congressmen and the American Medical Association recommending changes in both Titles XVIII and XIX of the Social Security



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*Blood; ketones; glucose; protein, and pH.

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Act. A number of suggestions have also been submitted on new regulations, particularly the one pertaining to reasonable charges by physicians.

The need for a possible extension of the military dependents contracts was discussed since new negotiations will be made on a usual and customary basis after receipt of statistics on the Kentucky Physicians Survey.

Public, Rural, and Occupational Health Committee

Walter L. O'Nan, M. D., Henderson, Chairman

KMA Headquarters Office **March 23, 1967**

In their second meeting of this associational year, the committee members reviewed actions that had been taken on previous recommendations and discussed uses of the Industrial Medicine Survey recently conducted by the committee through the KMA Communicator.

Other matters considered included the Diabetes Detection Program, mandatory measles immunization, Governor's Occupational Health Conference, and the AMA National Congress on Environmental Health.

Extended Blue Shield Coverage

Bills before at least eight state legislatures this spring would require local Blue Shield Plans to extend coverage to include services of non-physician practitioners such as optometrists, chiropractors and podiatrists.

The states in which such legislative action is currently pending are Arizona, Idaho, Kansas, New York, Oklahoma, Rhode Island, Washington, and West Virginia.

SPECIAL ARTICLE

(Continued from page 501)

It must be a part of every physician's routine for young children.

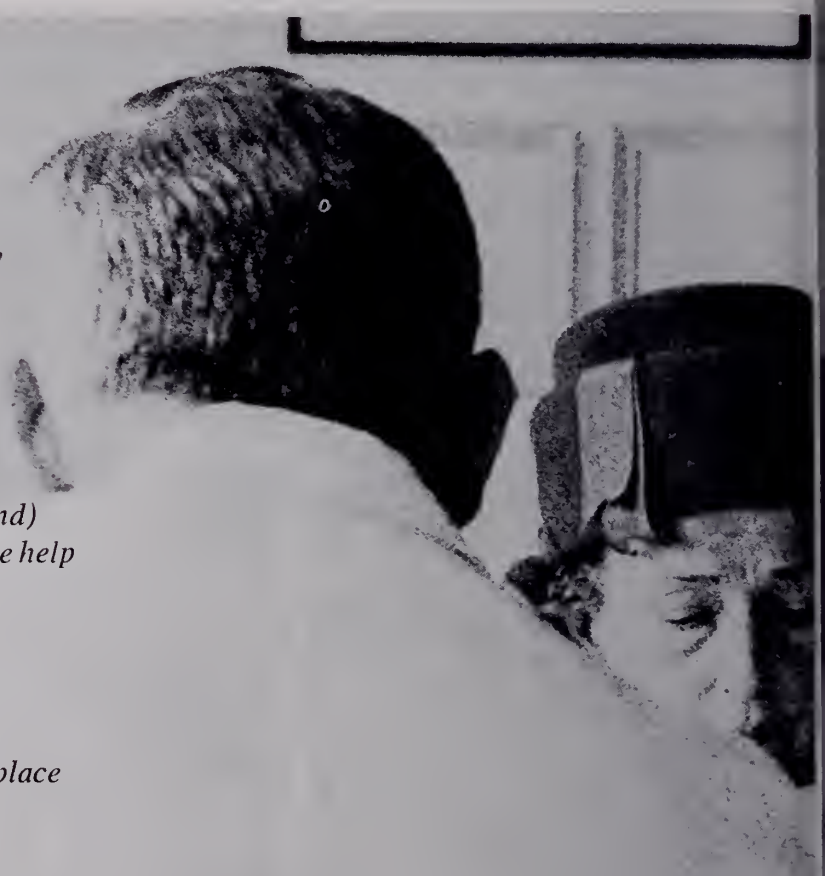
Some highlights of current vaccine research include the development of rubella and mumps virus vaccines, the latter of which may become available this year. Successful trial of a live oral vaccine against adenovirus type 4 has been carried out, this the most frequent cause of epidemics of severe, acute respiratory disease in military training camps.

The National Institute of Allergy and Infectious Diseases has a program well under way for development of vaccines against respiratory disease. Aims of the program include development of vaccines against respiratory syncytial virus; parainfluenza virus types 1, 2 and 3, which cause croup in children; mycoplasma pneumoniae, a major cause of pneumonia in adults; adenoviruses types 1, 2, 3, 4, 5 and 7, which cause acute febrile respiratory illness in children and young adults; and about 80 other viruses, including the rhinoviruses and entereviruses.

So you see with reasonable success from this research you will find us emphasizing a new area of immunization each year as we approach Kentucky Immunization Week.

The Mediatric Age:

There is a growing senescent body of people on their way to malignant inactivity, who sorely need your interest and direction to help them back to a more active and useful life. There are medicines too, designed to help. One such has proved useful in clinical practice.



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Cyanocobalamin	1.5 mcg.
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Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
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CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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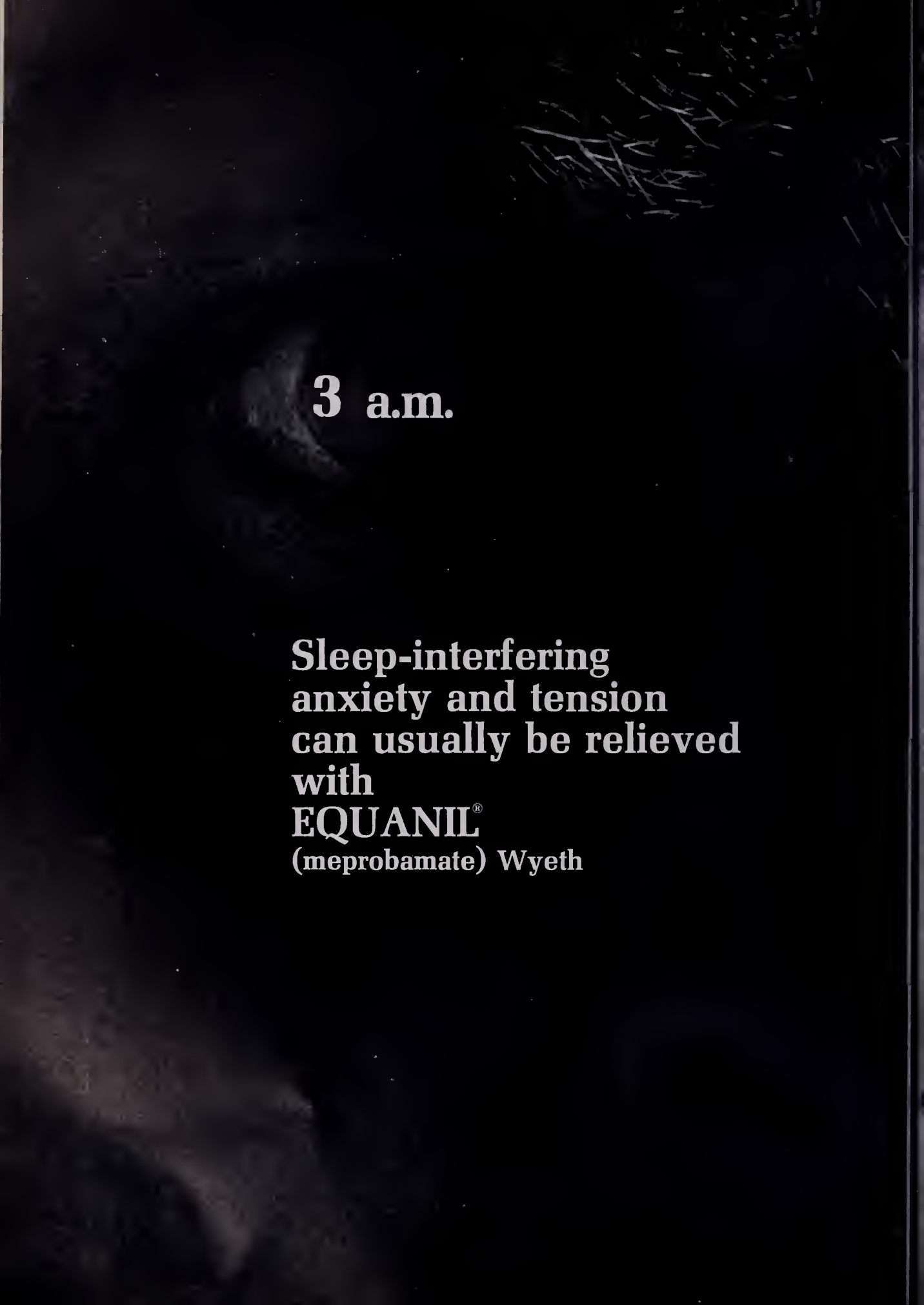


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Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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In Memoriam

HENRY B. ALLEN, M.D.
Lexington
1873-1967

Henry B. Allen, M.D., 93, Lexington, a retired physician, died March 29 at his home. Doctor Allen graduated from the University of Louisville College of Medicine in 1903 and practiced for many years in Morganfield before retiring and moving to Lexington.

MISCH M. CASPER, M.D.
Louisville
1878-1967

Misch M. Casper, M.D., 88, a general surgeon for 64 years, died March 17 at SS. Mary and Elizabeth Hospital in Louisville. Doctor Casper graduated from the University of Louisville Medical School in 1900. He was on the staff of SS. Mary and Elizabeth Hospital for 64 years.

JEROME COHN, M.D.
Lexington
1922-1967

Jerome Cohn, M.D., 44, associate professor in the department of medicine at the University of Kentucky Medical School, died April 3 in an airplane crash at Lexington. Doctor Cohn graduated from the University of Maryland School of Medicine in 1946. He was a member of the American Federation of Clinical Research, American Physiological Society, American Board of Internal Medicine, and a past president of the Kentucky Thoracic Society.

GEORGE F. DOYLE, SR., M.D.
Winchester
1878-1967

George F. Doyle, Sr., M.D., 88, a retired ophthalmologist and otolaryngologist, died March 22 at home. Death was attributed to a heart attack. Doctor Doyle graduated from Jefferson Medical College of Philadelphia in 1905 and practiced for 36 years in Winchester until his retirement in 1951.

CHARLES MAURICE EDELEN, M.D.
Louisville
1902-1967

Charles Maurice Edelen, M.D., a Louisville surgeon for 41 years, died April 11 at Kentucky Baptist Hospital. Death was attributed to a heart attack. Doctor Edelen, a graduate of the University of Louisville School of Medicine in 1926, was president of the Kentucky Surgical Society and a past president of the Kentucky Chapter of the American College of Surgeons.

LEWIS C. HAFER, M.D.
Hebron
1877-1967

Lewis C. Hafer, M.D., 89, a pioneer pediatrician in Northern Kentucky, died March 25 at his home after a long illness. Doctor Hafer graduated in 1902 from the Ohio Medical School, predecessor of the University of Cincinnati Medical College. He was a member of the Northern Kentucky Crippled Children's Society and served on the staffs of St. Elizabeth and Berea College Hospitals.

DAVID R. NAGLE, M.D.
Lexington
1924-1967

David R. Nagle, M.D., 43, an anesthesiologist, collapsed and died March 29 while assisting in an operation at Good Samaritan Hospital. Doctor Nagle graduated from the University of Iowa School of Medicine in 1949. He was a member of the Kentucky and American Societies of Anesthesiologists and the American Society of Clinical Hypnosis.

EDGAR W. NORTHCUTT, M.D.
Covington
1887-1967

Edgar W. Northcutt, M.D., 80, died January 1 at his brother's home in Erlanger. Doctor Northcutt, a veteran of World War I, graduated from the University of Louisville School of Medicine in 1912. He retired from active practice as a surgeon in Northern Kentucky several years ago.

ROBERT GLEN SPURLING, M.D.
Louisville
1935-1967

Robert Glen Spurling, M.D., 31, died April 7 at Jewish Hospital of a cerebral hemmorhage. Doctor Spurling, a pediatrician, had been practicing since July after completing his residency at Children's Hospital where he was chief of pediatric residents. He graduated from the University of Louisville Medical School in 1961.

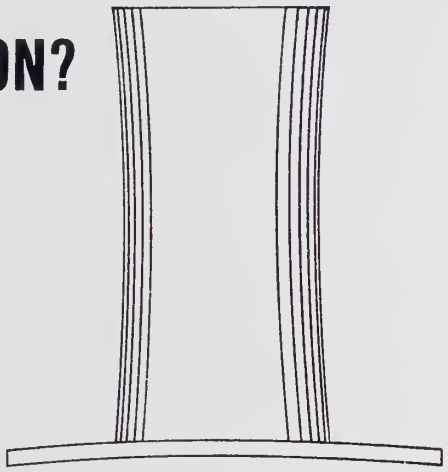
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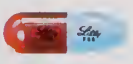
dications: Tuinal, comprised of equal parts of Seconal® odium (sodium secobarbital, Lilly) and Amytal® Sodium odium amobarbital, Lilly), is indicated for prompt and oderately long-acting hypnosis. Not suitable for con- nuous daytime sedation.

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recautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

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COUNTY SOCIETY REPORTS

McCracken

The regular monthly meeting of the McCracken County Medical Society was held at Boswell's Restaurant in Paducah on the evening of March 22.

During the business meeting plans were made for attendance at the KMA Interim Meeting at Ken-Bar Inn, April 19 and 20. Carroll W. Traylor, Calvert City, a member of the Marshall County Medical Society, was appointed as chairman to assist and represent the McCracken County Society at the meeting.

Walter Johnson, M.D., Society president, announced receipt of two letters concerning the establishment of a Cervical Cancer Screening Program in the McCracken County Health Department. These letters were referred to the Public Health Advisory Committee for study and a report at the next meeting.

Preceding the business portion of the meeting, Don L. Smith, M.D., dean of the University of Louisville School of Medicine, gave a report on the new curriculum and future plans of the school and showed slides of the proposed Medical School complex.

Sudden Hearing Loss

(Continued from page 492)

CASE #5

A thirty-one-year-old white female was seen in April 1965, with history of a hearing loss in the left ear. The patient was quite indefinite as to whether the hearing loss was of one month or of three months duration. She was admitted for therapy but showed no improvement in her hearing.

CASE #6

A forty-five-year-old white female developed severe, sudden, left hearing loss while under a hair dryer on 27 March 1964. This was associated with some tinnitus and vertigo. She was seen at her dispensary the following day and treated for labyrinthitis with antivertiginous drugs. After one week of therapy, with no response, she was referred to the Ear, Nose and Throat Clinic. Examination revealed a severe, sensory-neural hypacusia of 80 decibels. Caloric tests were equal and normal, bilaterally. The patient was admitted on 4 April and given 5 days of intensive vasodilating treatment. Audiogram on 16 April showed normal hearing in all the speech ranges.

Summary

Sudden, perceptive hearing loss, if treated early by a vasodilating regime, has an excellent chance of recovery. Recovery is directly related to the time between onset and treatment.

References

1. Sheehy, James L.: *Vasodilator therapy in Sensory-Neural Hearing Loss,* The Laryngoscope, 70: 885-914 (July) 1960.
2. Williams, H. L.: *Allergy of the Inner Ear,* Archives of Otolaryngology, 56: 24-44, 1952.
3. Hilger, J. A., and Goltz, N. F.: *Some Aspects of Inner Ear Therapy,* The Laryngoscope, 61: 697-717, 1951.

PUBLIC HEALTH PAGE

(Continued from page 468)

within the bounds of a single political jurisdiction. Since they are an area problem an area solution is called for. Perhaps none of us would agree as to just what the dimensions of such areas should be. Most of us, however, do agree that something larger than the single county approach is called for. In the interest of overall governmental program planning we may have to compromise a bit as to what we might feel is the ideal area of solution for problems of our particular interest, but since health problems are so interrelated and intertwined into other problems the greatest public gain could come from standard area groupings for all government programs.

While not specified in the law it is envisioned that area health planning councils will be established to insure attention to local interest and need. These would be patterned after the state council and would provide the organized base for requests to it. Here again is a great opportunity for members of our profession to exert their influence for public good, for certainly it would be hard to imagine such a group making recommendations without giving weighted thought to the thinking of its physician members.

There is much to be said in favor of P. L. 89-749. It generally represents an attempt to correct the widespread fragmentation of health programs which have confused the profession, cost the taxpayer and disillusioned the consumer. A mechanism has been prepared to use sound planning principles to pave the way for sound programs. It offers all of us a means to have a voice in the planning process whether we be professionals, interested citizens or consumers.

General Practice, grossing $56,000 a year, available in Ohio. Included is modern, air-conditioned building, complete equipment, drugs, records. Excellent clientele in pleasant small community with hospital. Doctor leaving to take residency. Available July, 1967. Liberal Terms, $23,000. Write: Robert E. Goyne, M.D., Route 5, Upper Sandusky, Ohio. This practice can be taken for 1 to 2 years also as a Locum Tenens on a financially very rewarding basis.

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Assistant Professor of Psychiatry and Medical Director
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*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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TB Assoc. Reelects Dr. Mardis

Richard E. Mardis, M.D., Louisville, a specialist in internal medicine, was reelected president of the Kentucky Tuberculosis and Respiratory Disease Association at a meeting in Lexington, April 5. Other doctors reelected at the meeting were Kurt Keuschle, M.D., Lexington, second vice president, and E. Rudolph Gernert, Louisville, treasurer.

Colby Cowherd, M.D., Lexington, and Carroll Witten, M.D., Louisville, were elected to the Board of Directors of the Association.

Congress Debates SS Amendments

Of the numerous health bills that have been introduced to the 90th Congress, most consideration is being given to a Social Security Amendment which would place all persons currently classified as permanently disabled, regardless of age, under the Medicare program.

The present Congress seems more thorough in its consideration of medicare-type legislation and less eager to take action in this area than its predecessor. Many attribute this to be the direct result that bipartisan political committees across the country, such as KEMPAC, had on the 1966 elections.

Public Health Assoc. Officers

Mrs. Sallie Taylor, a clerk in the Ashland-Boyd County Health Department, became president-elect of the Kentucky Public Health Association at its 19th annual meeting April 5 in Louisville. Miss Frances E. Goodman, Louisville, director of nurses at the Commission for Handicapped Children, took office as president for the coming year.

Joseph Durbin, Louisville, executive director of the Visiting Nurses Association, took office as vice-president. New members of the board of directors are A. S. Holmes, M.D., health officer for Laurel, Knox and Whitley counties, and Dan Tuttle, deputy state mental health commissioner.

Delayed Rupture of the Spleen

(Continued from page 490)

changed, the tube should be left in for continuous monitoring. Gauze can be placed over the end of the tube and the tubing anchored to the abdomen with an adhesive tape flag. A small amount of normal saline can be instilled into the peritoneal space and repeated aspirations done. In two cases known to the senior author an initial dry tap was obtained and subsequently blood drained from the indwelling polyethylene tube. In both cases exploratory laparotomy was done before vital signs changed.

In Sizer's collected series of 306 cases, correct diagnosis was made in only 20%. Only by careful study of the entire clinical profile of the patient, including the history, physical examination, repeated physical examinations, laboratory studies, repeated CBSs and x-ray examinations, and abdominal paracentesis with continuous monitoring with indwelling intraperitoneal polyethylene tube, can the diagnosis be made more frequently and earlier laparotomy and splenectomy expedited.

Summary

The serious nature of delayed rupture of the spleen following blunt abdominal trauma has been re-emphasized. The records of the 40 cases of splenic rupture secondary to blunt abdominal trauma at the St. Joseph Infirmary, Louisville, Kentucky from the year 1955 to 1965 have been studied and pertinent statistics are presented. Ten cases of delayed splenic rupture were found in this group of 40 patients. Two cases are presented.

A discussion of the clinical profile of delayed splenic rupture is presented. Pertinent laboratory studies are discussed. Abdominal paracentesis using the technique of Stephens and Amis is recommended in these cases of blunt abdominal trauma. The authors emphasize that the physician should be aware of the entire clinical profile of delayed splenic rupture. Only by careful study of the history, physical examination, repeated physical examinations and laboratory studies, and abdominal paracentesis can the diagnosis be made more frequently and exploratory laparotomy and splenectomy expedited.

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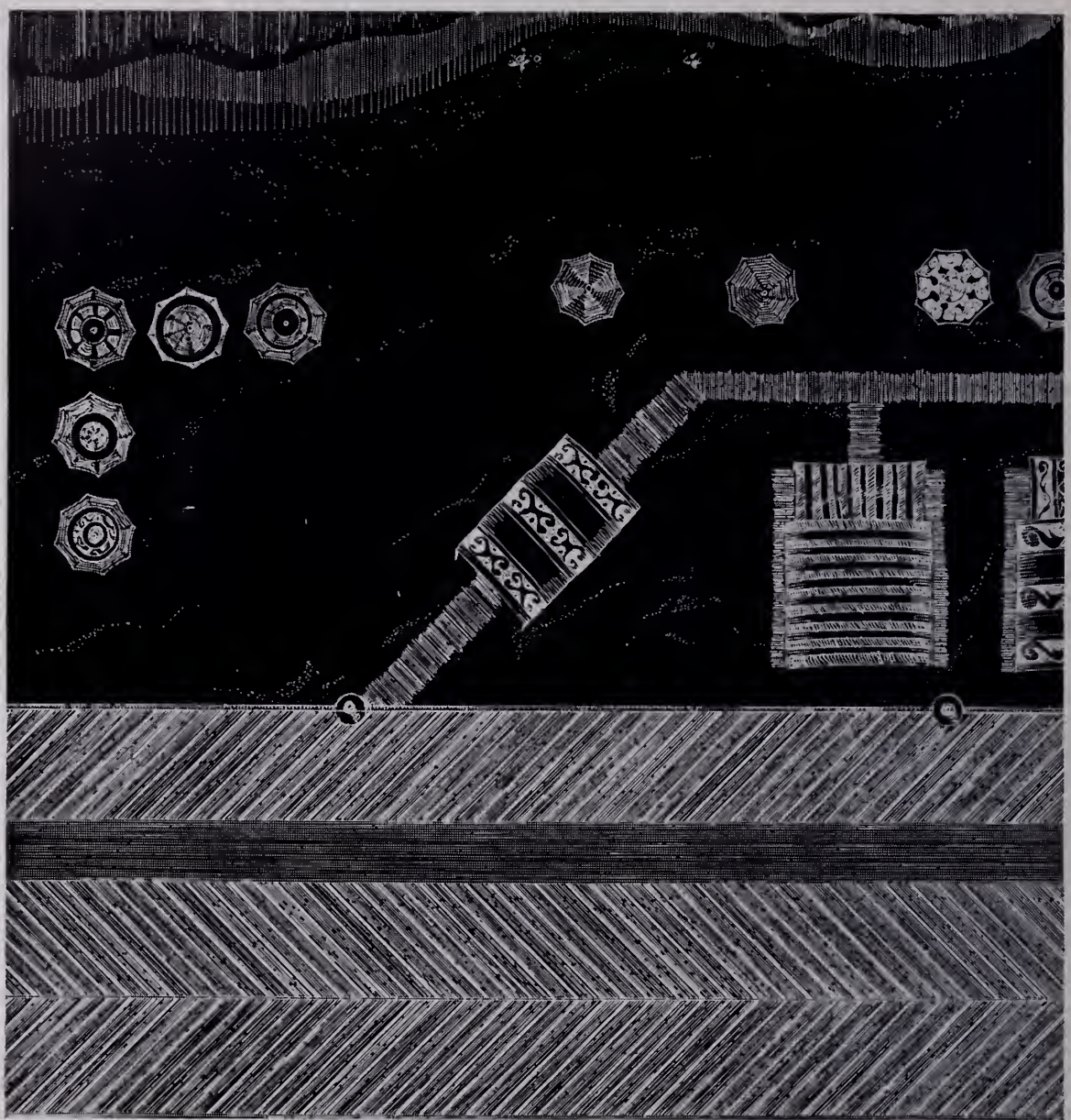
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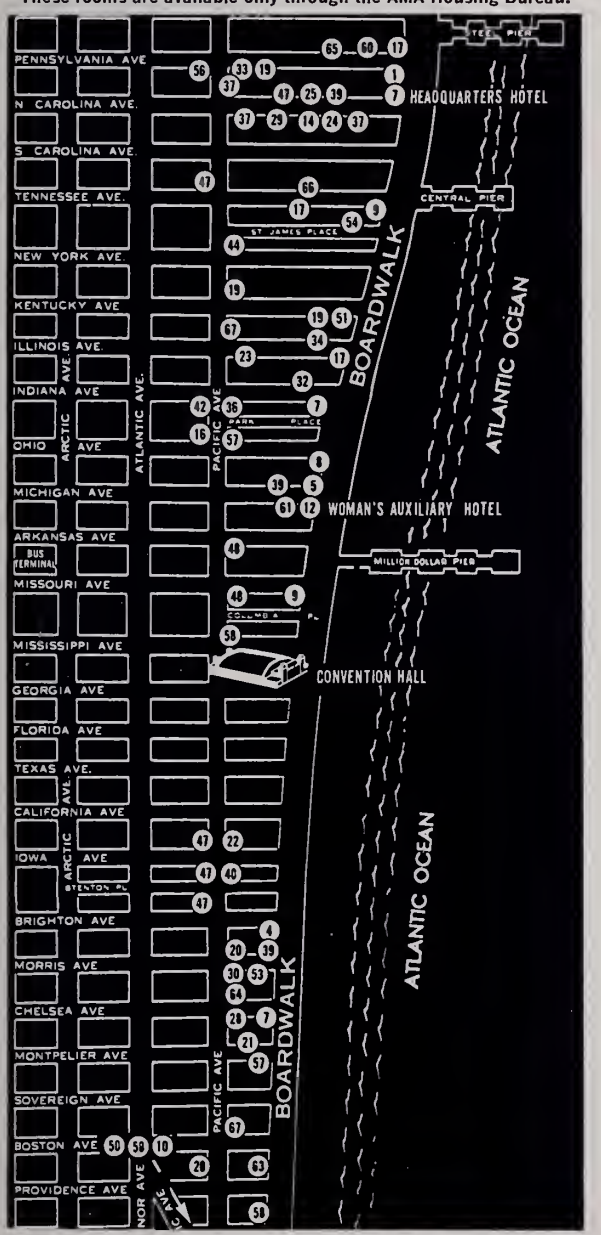
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In peptic ulcer... antacid therapy with a new benefit



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MESSAGE FROM THE PRESIDENT



OF MAJOR concern today of leaders in the health field is the shortage of medical manpower. Even though the health field now is the third largest in the number of persons employed, it is projected that within a few years the continuing demand for health workers will increase its rank to first in the number of participating personnel.

To illustrate the increasing demand for medical care, a few statistics may be found interesting. Between 1950 and 1960, while the population increased by 19 per cent and the number of general hospital beds by 25 per cent, the number of workers in the health service increased almost 60 per cent. In that same period all employment increased by 14 per cent.

Over the same period, the total supply of physicians increased at about the same rate as the population, professional nurses in hospitals by over 50 per cent, and practical nurses by 110 per cent. The number of medical records librarians doubled, the number of medical record technicians tripled. Aids and orderlies increased by two-thirds. The number of medical and x-ray technicians almost doubled.

Recruitment to medical schools has slipped. The length and cost of a medical education and the many competing, glamorous, and financially attractive opportunities that now exist for college graduates are factors in this decline. Not to be ignored as causes of this decrease are the continuous degrading and harrassment of the private physician by a liberal hostile press as well as the ever present threat of oppression of the profession by governmental domination.

Since the availability and accessability of medical care to all segments of the population directly reflect upon the public image of the private physician, it would behoove all of us to assist in every manner possible the recruitment of personnel and the development of training programs in all medical and allied fields.

Robert E. Pennington

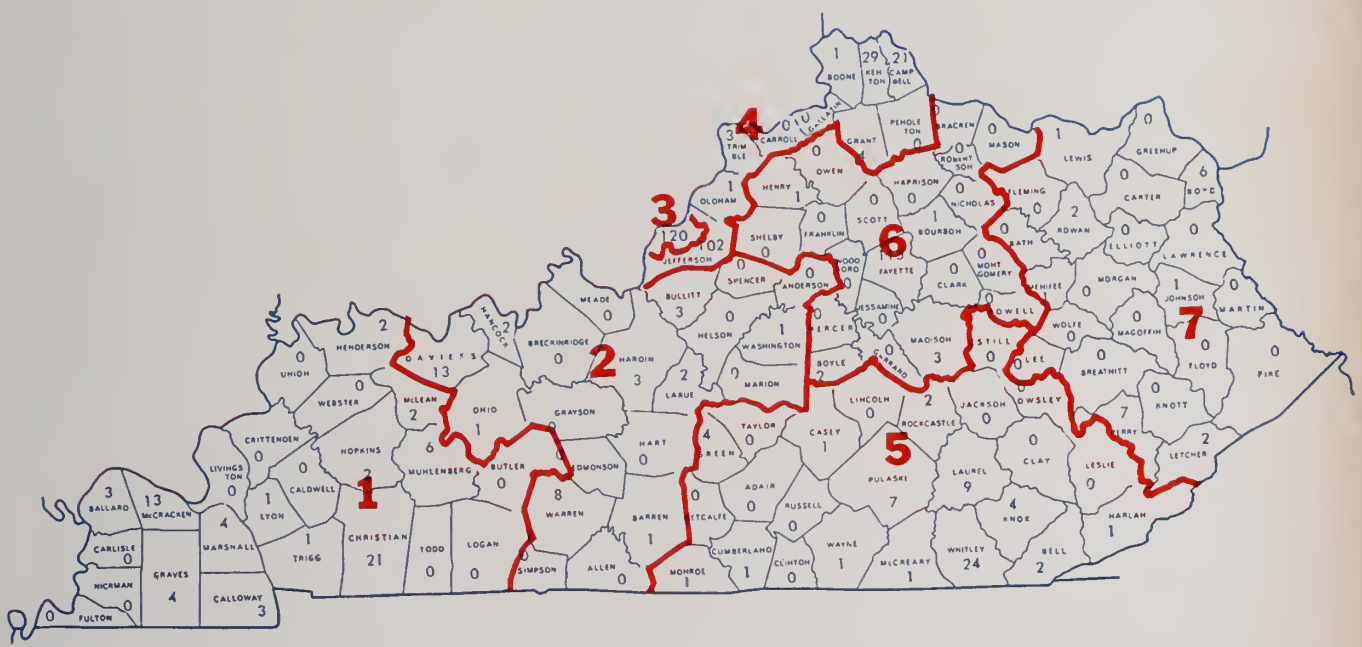
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7	231	16	4



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In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

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Therapy was given from three to 12 days, with an average of six days.

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A clinical cure rate of 94.5%

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87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

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53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

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Ames



RESUSCITATION OF THE NEWBORN INFANT AND RELATED EMERGENCY PROCEDURES — PRINCIPLES AND PRACTICE, Second Edition: Edited by Harold Abramson, A.M., M.D.; Published by the C. V. Mosby Company, St. Louis, 1966; 411 Pages; Price, $16.50.

The second edition of *Resuscitation of the Newborn Infant,* edited by Doctor Harold Abramson, has been considerably enlarged but basically it has been little changed.

The first edition is still here, with the same chapters, and almost the same text except for the addition of new tables and illustrations and the inclusion of more up to date references. There is still an able presentation of appropriate physiology and pathology. Doctor Abramson and his contributing authors then continue to champion the emergency treatment of asphyxia neonatorum principally by mechanical measures to clear the airway and assist ventilation. The disappointments of the first edition have also been preserved. These include especially the chapters on obstetrical anesthesia and on mechanical respirators.

The main distinction of this second edition is the addition of four new chapters covering acute anemias of the perinatal period, surgical emergencies, infections of the newborn, and fluid and electrolyte therapy of the newborn. These are important and interesting subjects and are well presented here although often in less detail than might be desirable.

The reviewer believes the new chapters would have been better published as a separate volume, perhaps entitled "Medical and Surgical Emergencies in the Newborn." Included in a fairly good textbook on resuscitation they are an afterthought, a fact that the editor acknowledges by adding parenthetically to the title of the edition . . . "and Related Emergency Procedures."

DONALD M. THOMAS, M.D.

THE HUMAN HEART: THE LAYMAN'S GUIDE TO HEART DISEASE: by Brendan Phibbs, M. D.; Published by The C. V. Mosby Company, St. Louis, 1967; 253 Pages; Illustrated; Price, $4.95.

Monographs on heart disease written by cardiologists for the layman have reached epidemic proportions. The format of all these publications is essentially the same. The opening chapters describe normal anatomy and physiology. The middle section is devoted to various pathologic states and the final chapters elaborate the author's general philosophy and approach to heart disease. This publication is no exception.

The anatomic and physiologic explanations given in the initial and midsections are too long and complex. He attempts to speak in layman's language but uses many medical terms that are not adequately defined.

The illustrations are a combination of poorly conceived cartoons and poorly captioned scientific drawings. The photographic reproductions are of inferior quality.

The author's attempt to write in both vernacular and scientific language has produced a book that is wordy and cumbersome. The material could have been distilled down to a publication one-third the final size.

This book is not recommended as a layman's guide to heart disease.

MORRIS M. WEISS, M.D.

STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY: by Harold F. Schuknecht, M.D., Werner D. Chasin, M.D., and John M. Kurkjian, M.D.; Published by The C. V. Mosby Company, St. Louis and London, 1966; 92 Pages; Price, $26.50.

The title of this book is somewhat misleading, as it is not a comprehensive coverage of mastoi dotympanoplastic surgery. It rather brings together three distinct points. The first is a brief discussion of the surgical implications of mastoidotympanoplastic surgery and the histopathology of chronic otitis media and mastoiditis. The second and most exhaustive portion could represent a monograph on the specific procedure which the author has adopted as the treatment for a particular problem. The third and concluding portion is a method for teaching temporal bone surgery to the resident staff.

The portion on histopathology superficially discusses the more important aspects of the problems and complications of this disease. The photo micrographs are excellent and demonstrate the various features being discussed.

The technique presented in the second portion is the use of a Type IV tympanoplasty, in association with obliteration of the mastoid cavity, followed by either primary skin grafting or delayed skin grafting. The procedure is extremely well detailed. The accompanying stereoscopic views completely demonstrate the procedure.

Statistical analysis of 116 patients operated with this technique is presented.

I feel that this book represents an excellent presentation of the procedure being described (second portion). It, however, presents little additional information.

GERALD D. LANDAU, M.D.



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of Kentucky . . .

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INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

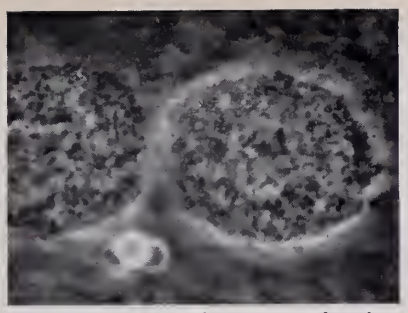


Visual evidence of how corticosteroids influence the inflammatory reaction

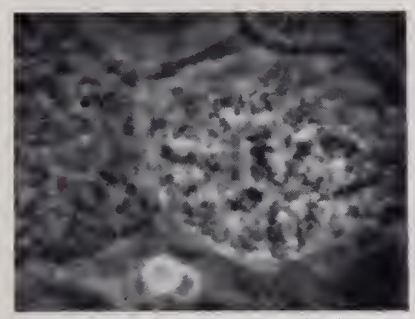
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



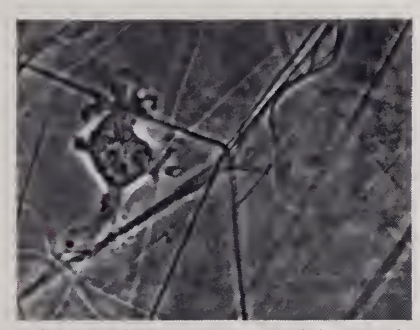
Phase-contrast microscopy showing mast cell before injury.



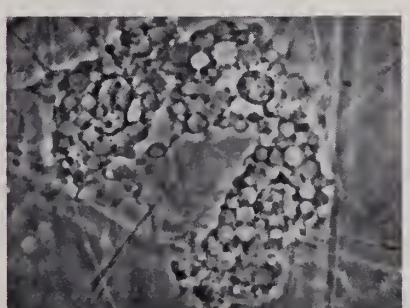
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

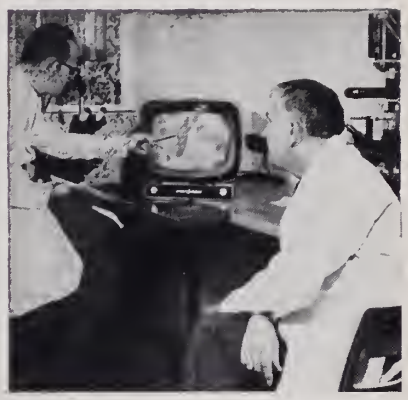
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



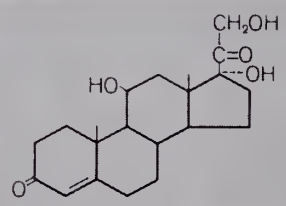
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

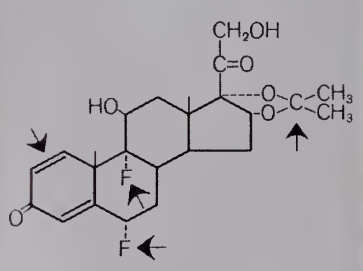
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

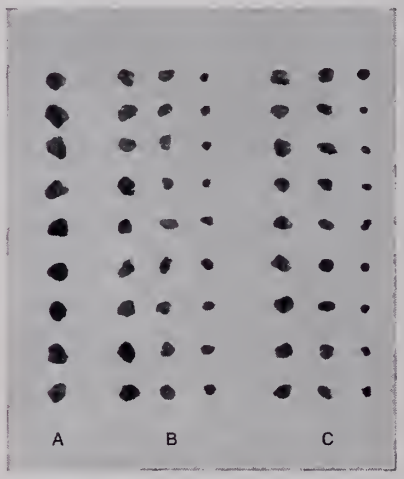


Fluocinolone Acetonide (Synalar)

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B—injected with 1, 2 and 4 mg. of hydrocortisone—show progressively smaller thymuses as does Group C—injected with fluocinolone acetonide—but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes. CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Bornan, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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12-16 Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment, U. of C. College of Medicine, Cincinnati, Ohio

12-22 American Medical Association Annual Meeting, Atlantic City

15-17 American Medical Women's Association, Denver

15-19 American College of Chest Physicians, Atlantic City

16-17 American Geriatrics Society, Claridge Hotel, Atlantic City

17 Conference of Presidents, Haddon Hall, Atlantic City

17-18 American Diabetes Association, Atlantic City

18-22 Woman's Auxiliary to the American Medical Association, Shelburne Hotel, Atlantic City

18-22 American College of Preventive Medicine, Atlantic City

26-29 American Orthopaedic Association, Hot Springs, Virginia

JULY

23-29 Southern Seminar in Obstetrics and Gynecology. Oak Grove Inn, Asheville, N.C.

AUGUST

21-24 American Hospital Association, Palmer House, Chicago

24-26 West Virginia State Medical Association, The Greenbrier, White Sulphur Springs

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their summer and fall meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Educational Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

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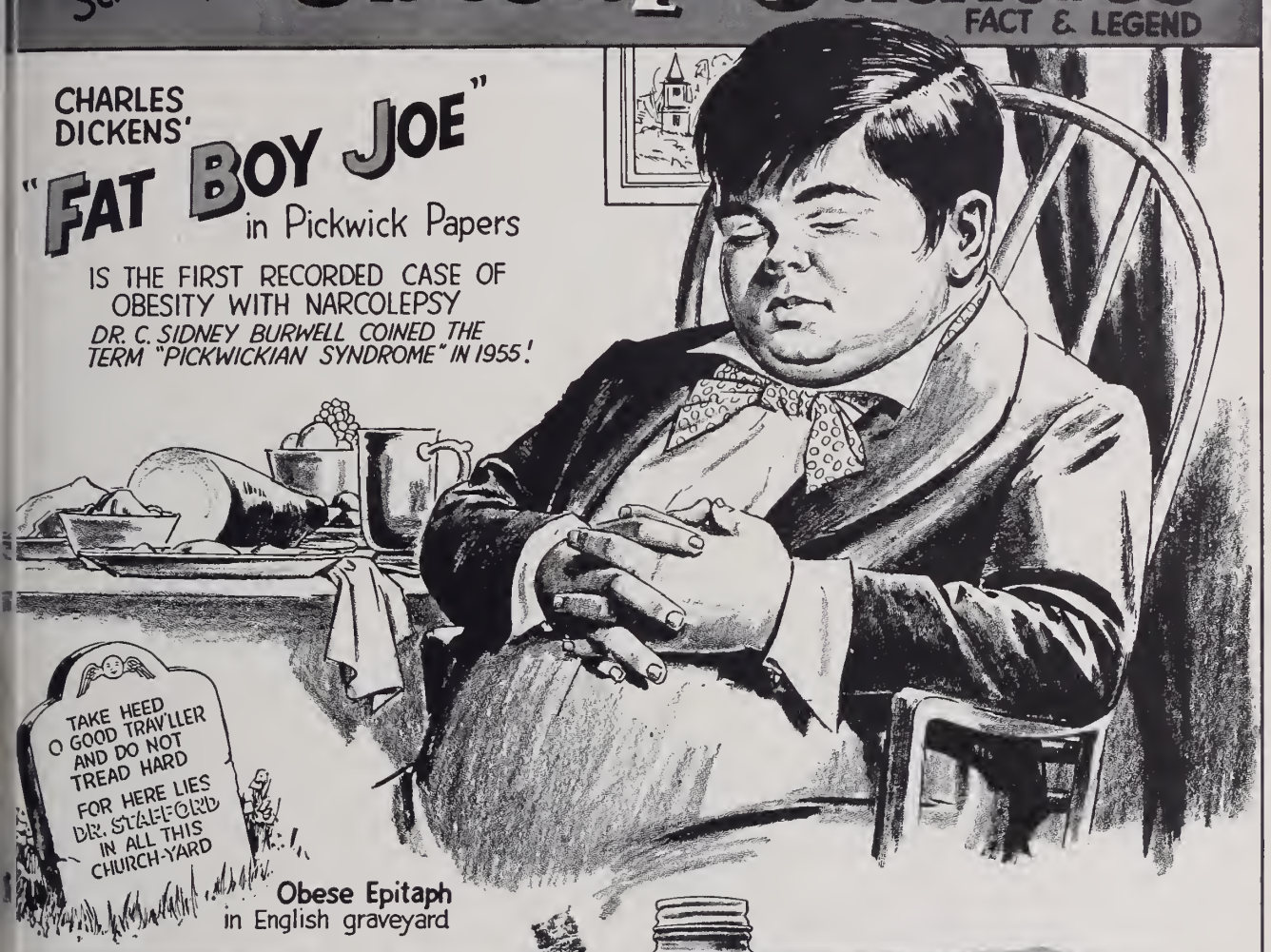
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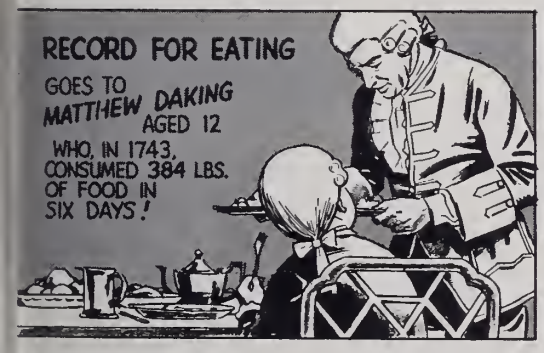
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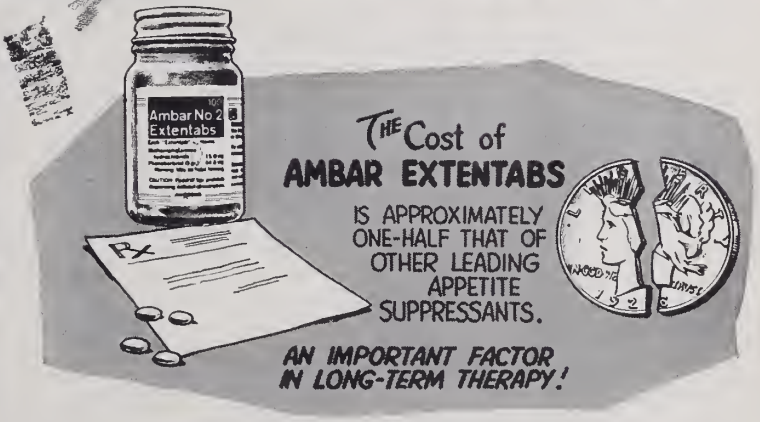
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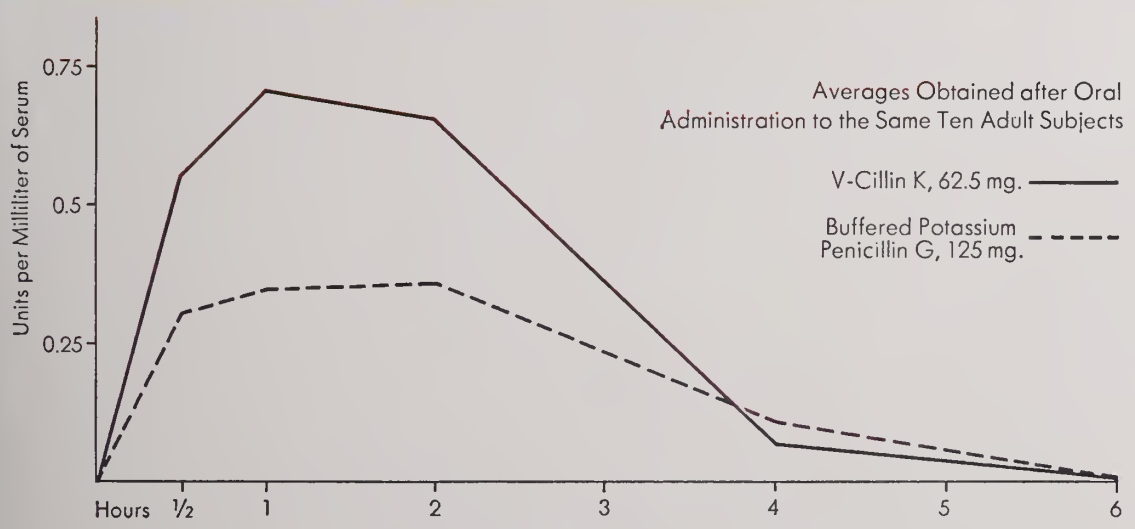
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Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

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Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

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Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

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Penicillin is a substance of low toxicity, but it does possess a si cant index of sensitization. The following hypersensitivity reac associated with the use of penicillin have been reported: skin r ranging from maculopapular eruptions to exfoliative dermatitis; caria; and reactions resembling serum sickness, including chills, f edema, arthralgia, and prostration. Severe and often fatal anaph has occurred (see Warnings). Hemolytic anemia, leukopenia, t bocytopenia, and nephropathy are rarely observed side-effects are usually associated with high parenteral dosage.

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Beta-hemolytic streptococcus infections without associated teremia may be treated with 200,000 to 400,0000 units three tim day. Therapy should be continued for a minimum of ten days to pr development of rheumatic fever and/or other serious complica Dosage for routine streptococcus prophylaxis in patients with a hi of rheumatic fever or congenital heart disease may be 200,000 once or twice daily. When such patients undergo tonsillectomy, extraction, or other minor surgery, the prophylactic dose shaul 500,000 units every six hours given two days prior to surgery an two days postoperatively. If oral medication is not feasible on the of surgery, parenteral therapy should be considered. Mild to m ately severe pneumococcus pneumonia has been treated effec with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be every six to eight hours in conjunction with indicated surgical p dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hou three doses may be employed; in females, 500 mg. every four for six doses are recommended. Refractory infections generally res to a second treatment three to four days following completion c first. Treatment of gonorrhea with severe complications shaul individualized, with prolonged and intensive treatment. Patients w suspected lesion of syphilis should have a dark-field examinatio fore receiving penicillin and monthly serologic tests for a minim three months.

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Utilization of Blood
A Single-Unit Blood Transfusion Study†

Edward J. Fadell, M.D.*
Louisville, Kentucky

An analysis of the single-unit blood transfusions is presented to improve the utilization of whole blood at the patient level. The percentage of transfused patients receiving one unit of whole blood was 25.75 per cent for 1965.

EFFECTIVE utilization of blood requires not only efficient collection, processing, and distribution methods, but also judicial selection of recipients. The present study undertaken at the Methodist Evangelical Hospital is an attempt to evaluate the utilization of blood at the patient level.

The five generally stated primary indications for transfusion therapy are: 1) To maintain blood volume and to prevent or treat shock; 2) To maintain the oxygen carrying of the blood; 3) To promote or maintain coagulation of the blood; 4) To administer exchange transfusions in the newborn infant; and, 5) To maintain circulation as in extra corporeal or cardiac bypass shuts. To some authorities, if these requirements can be satisfied by infusion of one pint of blood, the patient is felt no more in need of transfusion than the donor. The Joint Council states that a predominance of single unit transfusions implies a need for critical reassessment of blood usage in that hospital.[1] More specifically the American Medical Association's Committee on Blood, being cognizant of statements that either support or criticize transfusion of a single unit of blood, recognizes that the administration of blood involves many factors and medical considerations. Studies indicate that some single-unit blood transfusions associated with surgery may not be necessary, although in certain situations a transfusion of a single unit of blood may reflect sound judgment and be in keeping with good medical practice.[2]

We recognize that frequently in surgery, transfusion therapy appears indicated with the intent of follow up with additional blood replacement. However, it is not uncommon following the initial transfusion for the surgeon to note improvement in the patient's condition such that it is unnecessary to continue with additional blood therapy. Other instances of indicated single-unit blood transfusions are in treatment of patients with bone marrow depression who must be followed over a period of time with intermittent single-unit transfusions. Frequently, infants receive multiple transfusions from a single unit of blood. Additionally, there is that group of patients who die before a second unit of blood can be given.

†*The author expresses appreciation to the data processing personnel of Methodist Evangelical Hospital for help in compiling this data*

**Pathologist, Methodist Evangelical Hospital, Louisville*

With these thoughts in mind, single-unit transfusions were evaluated at this hospital. It was recognized that there are indications although perhaps limited for single-unit transfusions. Certainly proper utilization of blood is a good index of quality of patient care in a single institution.

Data

In our study, 19 items of information were tabulated on the patients receiving one unit of blood during any one admission. This particular group of patients was determined by sorting IBM punch cards which are made for every transfusion given. The patient's chart was then abstracted and the 19 items of information were punched on IBM cards for processing as partially shown (See Table I.) The items of information are hospital number, service, age, diagnosis, doctor's indication for transfusion, iron therapy prior to transfusion, B_{12} therapy prior to transfusion, type of transfusion, pre-transfusion hematocrit, pre-transfusion hemoglobin, serum iron, blood volume, death within 12 hours, immediate reaction to transfusion, antihistamines prior to transfusion, examiner's indication for transfusion, justified or unjustified transfusion. These items of information were selected to attempt measurement of the number of justifiable single-unit transfusions as well as to evaluate laboratory utilization for substantiation of the indications for transfusion and to attempt to determine the type of pre-transfusion medication a patient receives.

During the entire period of 1965, of the discharged patients who were transfused, 25.75 per cent received one transfusion. (See Table II). During the first six month period of 1966, 22 per cent of discharged patients who were transfused received one transfusion. During this period, constant surveillance of the blood transfusion records was carried out. This represents almost a three per cent decrease in a single-unit transfusion rate. At the same time, there was a 40 per cent overall increase in blood usage during the six month period. (See Table III).

TABLE I

SINGLE-UNIT TRANSFUSIONS

January 1, 1965 — December 31, 1965

I.	Service		
	Medicine	22	13.49%
	Surgery	100	61.34%
	Obstetrics and Gynecology	35	21.47%
	Others	6	3.68%
	Age of Patients		
	Less Than 5 Years Old	1	0.61%
	More Than 5 Years Old	162	99.38%
	Diagnosis		
	Type of Primary Blood Disease	4	2.45%
	Not Primary Blood Disease	159	97.54%
II.	Number of Deaths		
	Within 12 Hours of First Transfusion	5	3.06%
	Alive 12 Hours or More After Transfusion	158	96.93%
	Immediate Reactions to Transfusion		
	None	147	90.18%
	Allergic Reactions	2	1.22%
	Hemolytic Reactions	0	0.00%
	Chills and Fever	6	3.68%
	Bleeding Tendency	0	0.00%
	Others	8	4.90%
III.	Antihistamine RX Prescribed Prior to Transfusion		
	Yes	38	23.31%
	No	125	76.68%
	Iron RX Prescribed Prior to Transfusion		
	Yes	9	5.52%
	No	154	94.47%
	B_{12} RX Prescribed Prior to Transfusion		
	Yes	8	4.90%
	No	155	95.09%

TABLE II

SINGLE-UNIT TRANSFUSIONS

January 1, 1965 — December 31, 1965

Total Discharges Receiving Transfusions	633
Total One Unit Transfusions	163
Percentage of Patient Discharges Receiving One Transfusion	25.75
Total Units of Blood (Whole Blood and Packed Cells)	1,726

Discussion

In 1966, the overall percentage of patients receiving one transfusion, that is approximately 22 per cent, is not considered excessive at

TABLE III

SINGLE-UNIT TRANSFUSIONS

January 1, 1966 — July 31, 1966

I.	Total Patients Transfused	426
II.	Total One-Unit Transfusions by Patient	103
III.	Total Discharges Receiving Transfusions	474
IV.	Total One-Unit Transfusions by Discharges	104
V.	Percentage of Patient Discharges Receiving One Transfusion $\frac{(104)}{474}$ 100 =	22.0%
VI.	Total Discharges (Adults)	7,696
VII.	Total Discharges (Adults and Newborn)	8,395
VIII.	Total Units of Blood (Whole Blood and Packed Cells)	1,451

this time. It is to be noted that approximately 82.8 per cent of the single-unit transfusions were given on the surgical and obstetrical services. This coincides quite well with other studies. A recent review in the *Journal of the American Medical Association* from a large hospital revealed that approximately 29 per cent of transfused patients received a single-unit of whole blood or packed red blood cells.[3] The paucity of individuals less than five years of age receiving blood in our institution is the consequence of the lack of pediatric facility. It should be noted that only a very small percentage, namely 0.61 per cent, was given a single-unit blood transfusion in this category. It is felt that the number of transfused patients less than five year of age, patients with primary blood disease, and patients who die within 12 hours of the first transfusion had ample reason for receiving a single-unit transfusion. Of the 25.75 per cent single transfusion rate, 6.12 per cent represents patients of these three groups. According to the indications for transfusions as written on the patient's chart by his doctor, 40 per cent of the single-unit transfusions were for hemorrhage, shock, burn, or anticipated blood loss at time of surgery. The fact that approximately half of the individuals who receive blood have hemoglobins in the range of 10 or more grams would seem to indicate that the majority of surgical patients, at least prior to surgery, had essentially normal hemoglobins and hematocrit values. Generally, at the time of surgery when blood is replaced, hemoglobin determination is not ordered and only the physician's judgment is used.

Retrospective evaluations of the indications for single-unit transfusions or even multiple transfusions in many individuals is most difficult. This difficulty lies in the fact that indications for transfusions are frequently not recorded in the patient's chart by his physician. In our study, in 44.78 per cent of the instances the indications were not listed. In such cases the examiner using the chart reconstructs the clinical situation and determines the indication. In our review, as in most reviews, the surveying physician felt that approximately 31.9 per cent of the single-unit transfusions. actually served a purpose. At Methodist Evangelical Hospital, the single-unit transfusion rate of 22 per cent in 1966, as compared to other reviews, is not excessive.

Conclusion

As in all retrospective reviews, a physician reviewing a patient's chart is at a disadvantage in evaluating the judgment of the clinician who is in attendance at the time a medical decision is made. One can only make a suggestion that perhaps further efforts in monitoring the single-unit transfusions will be accompanied by a continued reduction in the use of a single unit of blood. It is expected that as the study continues, the rate of single-unit transfusions will steadily decrease to perhaps 10 to 15 per cent of the total number of patients tranfused.

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Hypertension with Arteriolosclerosis in Childhood: Report of Two Cases †

Edwin P. Scott, M.D., F.A.A.P., F.A.C.P.*
and
Cathryn C. Handelman, M.D., F.A.A.P.**

Louisville, Ky.

Two childhood cases of arteriolosclerosis with malignant hypertension, with autopsy findings are herein reported.

ARTERIOLOSCLEROSIS with malignant hypertension is extremely rare in childhood. Guild, *et al*[1], in 1938, reviewed the literature and summarized twenty probable cases and reported two cases of their own. Both cases had abdominal symptoms, pain and melena. One showed intestinal ulceration, adhesions, obstruction and perforation.

Court[2], in 1941, reported a 10 year old with malignant hypertension who displayed papilledema, retinal exudates and hemorrhages, hematuria and arteriolar necrosis of the renal vessels. The characteristic vascular findings, endarteritis fibrosa and acute arteriolar necrosis, were present in the kidneys, bowel, spleen, pancreas and adrenals.

Zuelzer, *et al*[3], in 1951, reported two cases of arteriolonecrosis of the kidneys. They stated that hypertension is generally regarded as the cause, not the effect, of renal arteriolar necrosis. Since one of the two cases reported had had an injection of horse serum, a state of vascular hypersensitivity could have led to the development of the vascular lesions with hypertension, which in turn led to renal arteriolonecrosis.

Foman, *et al*[4], in 1952, reported a 7 year follow-up of a 12 year old who had malignant nephrosclerosis with papilledema. Terminally this patient vomited blood and passed blood in the stools and died from intestinal obstruction. At autopsy the heart weighed twice the normal. There were atheromatous plaques in the mitral valve, in the intima of the coronary arteries and in the aorta and the celiac, mesenteric and iliac arteries. The kidneys were of average weight and on microscopic examination revealed generalized hyperplastic arteriolosclerosis.

Haggerty, *et al*[5], in 1956, presented nine cases of essential hypertension. One of these patients had papilledema and an enlarged heart. Renal biopsy revealed minimal arteriolar sclerosis.

One of the most recent reports of apparent arteriolonephrosclerosis was by Meilman, *et al* in 1961 of four cases of hypertension in children.[6] One, a girl aged 12 years, had headache, papilledema with hemorrhages and exudate, proteinuria, red blood cells and white blood cells with clumps in the urine. The right kidney, on intravenous pyelogram, appeared quite small and when surgically removed weighed 30 grams. The pathological diagnosis was hypoplastic kidney with chronic pyelonephritis and arteriolonephrosclerosis. In the ensuing 10 months the blood pressure remained normal and all traces of papilledema, exudates and hemorrhages vanished. The arterioles showed a mild degree of narrowing. The urine returned to normal.

It is our purpose to present two additional cases of arteriolosclerosis with marked hypertension and their post-mortem studies.

Case 1

W. S., an eleven year old white female, was admitted to Children's Free Hospital on September 8, 1943. Chief complaint was intermittent attacks of frontal headaches often

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***Assistant Clinical Professor of Pediatrics, University of Louisville School of Medicine.*

associated with vomiting. With the attacks there was extreme drowsiness and she toppled when she walked.

Past history revealed poor school progress, poor dietary habits, deformity of chest noted at age two, and increased skin pigmentation for the past few years. Genitourinary symptoms were frequency and enuresis. Her mother had neurofibromata.

Physical examination revealed a temperature of 100.4 F., pulse 100, respiration 24 per minute and blood pressure 190/160. She was poorly nourished, appeared older than the stated age and diffuse brown pigmentation was present over face, neck and trunk. She had marked nystagmus and nuchal rigidity. Chest was "pigeon chest." Cardiac findings were generalized enlargement and grade IV-VI systolic murmur with greatest intensity over the apex. There was bilateral papilledema.

Laboratory studies:

CBC: Red cell count 6,500,000.
Hemoglobin 16 grams per 100 cc. of blood.
White cell count 21,00: polys 86%, lymphs 14%.

Urine: pH 6.0.
Specific gravity 1.031.
Albumin 4+; sugar negative.
Microscopic: 3-5 W.B.C./h.p.f.
5-8 R.B.C./h.p.f.

N.P.N.: 43.3 mgm. %
Creatinin: 8 mgm. %
Specific gravity of plasma: 1.023
Plasma CO_2: 43 vol. %
Lumbar Puncture:
Slight increased pressure.
1,200 R.B.C./cu. mm.
Globulin 2+
Sugar 110 mgm. %
Protein 90 mgm. %
Chloride 335 mgm. %
Blood Kahn: negative.
Chest and skull x-rays: negative.

Treatment consisted of a salt free diet, intravenous hypertonic glucose and intramuscular magnesium sulfate.

Clinical course in the hospital was downhill. She remained drowsy to semi-comatose and frequently vomited. Her temperature ranged from normal to 105.2° F. Urinary output was scant, with persistent albuminuria and specific gravity from 1.005 to 1.012. Blood pressure ranged from 160/120 to 200/160 mm. of mercury. She died on September 14, her fifth hospital day.

Post-Mortem

Gross:

The body was that of a white female, weighing approximately 60 pounds. There was slight jaundice of the skin and sclerae. The heart was four and one-half times normal size and weighed 180 gm. The left ventricular wall measured 2 cm. in thickness, and the right .5 cm. The descending branch of the left coronary artery was very much enlarged, sclerotic and tortuous. There were small arteriosclerotic plaques in the aorta. Appearance of the lungs was consistent with a lobular pneumonia. There were many small areas of hemorrhage in the gastro-intestinal tract. The kidneys were extremely small; the left weighed 40 grams, the right weighed 15 grams. The capsules were adherent and when removed left a granular surface. The left kidney had a notch opposite the hilus and in this area the cortical and medullary tissue was absent, leaving only a calyx extending into it, surrounded by fibrous tissue. In both kidneys it was impossible to differentiate cortical and medullary tissue. There were numerous small yellow streaks scattered throughout the parenchyma. The pelves were hyperemic and contained a small amount of purulent material.

Examination of the brain revealed all convolutions to be flattened. After fixation the vessels at the base were found not sclerotic.

Microscopy

There was proliferative thickening of the walls of the heart vessels, which was most marked in the intima. The lumen of the descending branch of the left coronary artery was narrowed to a mere slit by a great proliferation of fibrous tissue in the intima. Vacuolization was seen in the walls of some of the vessels, suggestive of cholesterin spaces.

There was hemorrhage, necrosis and ulceration of many small areas of mucosa throughout the gastro-intestinal tract.

In the kidney there were broad areas of scarring and destruction. The latter was so extensive in some fields that it appeared to be the result of infarction. Throughout there was

a moderately intense chronic inflammatory infiltrate.

The basic alteration was of the small arteries and arterioles. These were enlarged in diameter and the walls were greatly thickened. There was an increase in the thickness of the muscularis and also marked subendothelial proliferation in some vessels.

The glomeruli often showed some pericapsular fibrosis and lobular sclerosis. There was no inflammation within them. The tubules showed secondary atrophy and infrequent calcification. (See Figure 1).

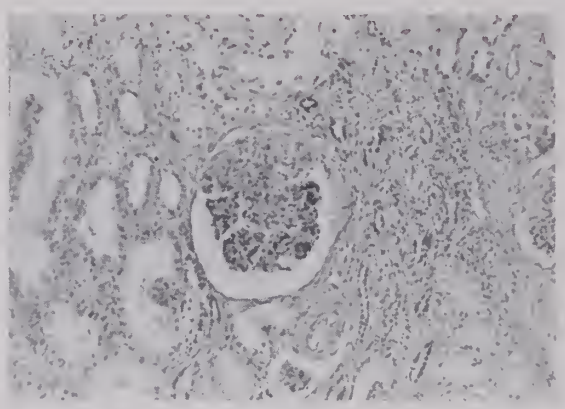


FIGURE 1.
Case 1

The final diagnosis was nephrosclerosis with generalized arteriolosclerosis.

Case 2

This twelve year old colored male was admitted to Children's Hospital on March 24, 1961, with the chief complaint of dizziness, blurred vision, rectal bleeding and high blood pressure.

His illness began approximately eighteen months prior to admission, at which time his mother said his "kidneys stopped working." At the same time, he began to complain of dizziness and blurred vision. He was studied by two physicians who could find no ocular pathology. The mother stated he had periodic spells of dizziness and vomiting.

One month before admission he was accidentally kicked in the abdomen and was admitted to the Frankfort Kentucky Hospital on February 27, 1961, with the chief complaints of dizziness and headache. While in the hospital it was found that his blood pressure was elevated and his urinary findings consistent with the diagnosis of nephritis. No specific treatment was instituted other than a salt free diet and he was discharged thirteen days later.

Two days before admission to Children's Hospital, he passed bright red blood in his stools.

Past history was non-contributory.

On physical examination he had a temperature of 99° F., a pulse of 110, blood pressure 156/85 and respirations of 24 per minute. There was marked dyspnea on slight exertion, and he was thin, emaciated, acutely and chronically ill.

His heart had a loud, blowing, grade 3 systolic murmur over the entire precordium. A late grade 2 diastolic murmur was heard at the base. The abdomen was full compared to his cachectic appearance. His feces were dark brown. Digital and sigmoidoscopic examination were negative.

Other than hypoactive reflexes, the neurological examination was not remarkable. The ophthalmoscopic examination revealed papilloedema.

Laboratory studies:

CBC: Red cell count 1,450,000.
Hemoglobin 3.3 grams per 100 cc. of blood.
White cell count 11,500: segs 87%, lymphs 5%, stabs 3%, monos 5%, sickle cell preparation negative.

Urine: Specific gravity 1.010.
Sugar negative.
Acetone negative.
Albumin negative.
Coproporphyrins negative.
Microscopic: 0-2 WBC/h.p.f.
Negative culture.

Carbon dioxide combining power measured 19.5. vol. %
Chlorides: 88.4 mgm. %
N.P.N. 69 mgm. %
Glucose: 93 mgm. %
pH 7.455
Blood potassium 3.2 mEq.
Sodium 13.3 mEq.
Stool examination: Positive for occult blood.
Negative for ova and parasites.
Urinary catacholamines: normal.

Chest Roentgenograms: slight generalized cardiomegaly.

Skull, long bone and abdomen roentgenograms: negative.

Intravenous pyelogram: extremely small, fairly well functioning and adequately draining left kidney, compatible with Goldblatt kidney. Right kidney, some compensatory hypertrophy.

Colon: normal both by opaque media and contrast air.

Upper G.I. series: normal.

Electrocardiogram: marked left ventricular hypertrophy.

On the second hospital day, his blood pressure was 200/140mm. Hg. with a venous pressure of 200 mms. of water. He was started on Serpasil® and Apresoline® and given oxygen and packed red blood cells intravenously. In spite of treatment, his blood pressure rose as high as 270/210. Because of failure to respond, his left kidney was removed on April 6, 1961. It measured 5 x 4 x 3 cm. and weighed 33 grams. The capsule stripped with ease and microscopically there were focal areas of poorly differentiated tubules. The glomeruli showed a marked decrease in the number of capillaries. The small arteries had a prominent hyperplasia of the media and some intimal hyperplasia. There also were areas of hemorrhage and lymphocytic infiltration beneath the epithelium of the calyces. The diagnosis was dysplasia and chronic pyelonephritis, mild.

Following surgery, he continued to have periodic severe abdominal pain with rectal bleeding without a known specific cause.

On April 27, 1961, approximately one month after his admission to the hospital, an exploratory laparotomy was performed. A volvulus of the ileum with perforation was found. Approximately 60 cms. of gangrenous bowel was excised and an ileo-ileostomy was performed.

The bowel on microscopic examination, was markedly edematous with areas of hemorrhage. There was diffuse acute inflammatory infiltration. The small arteries had striking hyperplasia of the media and proliferation of the intima. The impression was that this represented a congenital hyperplastic anomaly of the arteries with thrombi and inflammation of the ileum.

The postoperative course was uneventful, yet he continued with his marked hypertension, rectal bleeding and abdominal pain.

Because of signs of intestinal obstruction, he was again explored on May 2, 1961. A perforation at the previous suture line and more gangrenous ileum was found. Approximately 43 cms. were removed, and an end-to-end anastomosis done.

On May 10, 1961, his wound eviscerated and retention sutures were inserted.

An esophagram was done on the following day. There were no esophageal varices, ulcers in the stomach or duodenum, but opaque media was noted in the peritoneal cavity.

He was again explored on May 12, 1961, and found to have a perforation of the stomach which was repaired.

Two days later, because of continued hematemesis and rectal bleeding of bright red blood, he was again explored. A large bleeding artery was found at the upper edge of the previous gastric perforation and was ligated.

Repeat urinalysis showed the albumin to range from 0 to 2 plus, white blood cells 0 to 4, red blood cells 2 to 3 and an occasional hyaline epithelial cell per high power field. His blood pressure continued to be elevated, ranging from 130 to 230/110 to 180.

Despite a total of 27 transfusions of plastic bag fresh whole blood during his final two weeks, as well as adequate intravenous electrolyte therapy, steroids, 100 mgms. of testosterone weekly, vitamins, antibiotics, etc., he continued a downhill course with massive hematemesis and rectal bleeding. On May 14, 1961, he had a convulsion and died.

Post-Mortem

Gross:

The body was that of a young, emaciated Negro male, weighing 36 pounds. There was edema of feet and ankles.

The peritoneal cavity contained 100 cc. of cloudy, sanguinous, brown fluid. The left kidney was absent. The pattern of the intestines was distorted by recent surgery.

The heart weighed 250 grams and was enlarged, chiefly the left ventricle. The coronary vessels were prominent and on cut surface were markedly thickened.

The stomach was edematous and its rugal pattern was completely destroyed. The anterior

wall repair was intact. The previous anastomosis was necrotic.

The right kidney weighed 35 grams. The capsule stripped with moderate difficulty. Cut surface of the kidney was markedly injected and had numerous petechial hemorrhages.

Microscopic:

In the region of the apex of the heart there was ischemic necrosis of varying ages. One of the major coronary arteries had an asymmetrical area of thickening and degeneration of the wall. Other coronary branches were markedly hypertrophic. All small arteries of the gastrointestinal tract were prominent and extremely thick-walled.

The kidney showed diffuse interstitial fibrosis, and all branches of the renal artery were markedly hypertrophic.

The lumens of the renal arteries were severely narrowed. There was no degeneration of the arteries, but rather an increase in the thickness due to an increase in the thickness of the media, although subendothelial thickening was present. There was a small amount of hemorrhage of a focal nature, and focal dilitation of the tubules and sclerosis of the glomeruli. (See Figure 2).

The conclusion from the autopsy was an unusual arterial hypertrophy, affecting the small and middle-sized arteries more severely. Histologically, the lesions were marked by a tremendous increase in the thickness of the media. The lumens of the affected vessels were patent, yet reduced in size.

The lesions were most striking in the kidney; the small arteries being most affected.

The pathologist's* opinion of this disease was that the generalized nature of the disease may well represent a congenital malformation of the small arteries. The opinion was based on the fact that the arteries did not show the alterations usually associated with secondary hypertrophy and were generally free of degeneration.

It is believed that the clinical course can be explained, to some extent, on the basis of the anatomic findings, for it is probable that the effects of the diminished blood-flow seen in the heart in the form of ischemic myocardial necrosis were also present in the bowel in much more rapid and dramatic form. The hypertension undoubtedly was secondary to renal ischemia.

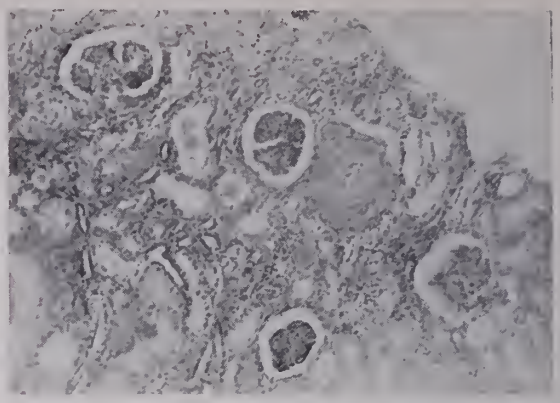


FIGURE 2.
Case II

Daniel Stowens, M.D., Former Associate in Pediatrics, Associate Clinical Professor of Pathology, University of Louisville School of Medicine and Director of Laboratories, Children's Hospital, Louisville

Discussion

Arteriolosclerosis with malignant hypertension is extremely rare in childhood. The term malignant nephrosclerosis is sometimes used to indicate a specific lesion in patients with malignant hypertension. Malignant hypertension is the terminology used when there is papilledema with persistent hypertension.

The two cases reported here fit the criteria for classification as arteriolosclerosis with malignant hypertension or malignant nephrosclerosis.

Summary

Two cases of arteriolosclerosis in childhood with hypertension that displayed the typical symptoms are reported.

In Case 1 the kidneys were the size of those of an elderly adult. Case 2 may well represent generalized congenital malformation of the small arteries.

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The Surgical, Psychiatric, and Sociocultural Implications of Pelvic Exenteration on a 2-1/2 Year-Old Female

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Implications of Treatment with Pelvic Exenteration of Sarcoma Botyroides in a 2½ year-old female.

PELVIC exenteration is reserved for the most serious of invasive tumors and requires the utmost of consideration by those involved with the decision. Such a decision, difficult enough to make when an adult female is involved, is far more difficult when a 2½ year-old female is the patient.

The purpose of this paper is to discuss the probable surgical, socio-cultural, and psychiatric effects of this procedure on the future of a child and how these might influence the decision to do such surgery.

J. K. was a 2½ year-old well developed, attractive child with an unremarkable medical past history. She was born out of wedlock. The first 18 months of her life she lived with her mother in circumstances that were less than desirable. She was then placed with foster parents with two grown married children of their own. The foster parents adopted her. She presented to our hospital center with a six-week history of vaginal bleeding. Upon examination a grape-like mass was seen protruding from her vagina. This mass was biopsied and the diagnosis was sarcoma botyroides. The treatment decided upon was pelvic exenteration, with the exception, in this case, of the ovaries. Such a procedure included the radical removal of the vulva and the development of a sigmoid conduit as well as a colostomy.

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It was apparent to all concerned with the decision to operate that more than merely physical health was involved. How would this child adapt to her deformity? How would society accept her? Were we to make an iatrogenic freak of this child? These were but a few of the many questions which required much thorough searching on the part of all concerned. It was decided to present the views of the three specialists involved with this case, the gynecologist, the child psychiatrist, and the behavioral scientist. For lack of data concerning this subject no dogmatic statements can be made, but every topic has its beginning and we hope that more discussion and research will be stimulated by this paper, thus propagating the holistic approach to patient care.

Surgical Implications

Sarcoma botyroides is a rare malignant mesenchymal tumor, usually classified with the mixed mesodermal tumors. Such tumors may occur in any hollow viscus, and are most frequently seen in the vagina, bladder and gall bladder. These tumors are extremely malignant and frequently rapidly fatal. Sporadic reports of therapeutic successes do appear in the literature, most commonly associated with radical surgical procedures. The tumors are relatively radio resistant. Daniel, Koss, and Brunschwig[1] reported a series of 13 cases with two survivors, both treated by exenteration. They point out the fact that these tumors are frequently multicentric in origin and anything less than radical surgery may allow persistence or recurrence of disease. Although others have achieved cure by less radical procedures, the majority of cures are obtained by at least radical hysterectomy and vaginectomy. As pointed out by Daniel, et.al. and by Ober[2], a patient treated for sarcoma botyroides who lives for one or two years will generally proceed to long-term survival.

The present case is a 2½ year-old female with a history of vaginal bleeding and a polypoid mass in her vagina. The decision to do total pelvic exenteration was based on several factors. The first of these was the experience of others as reported in the literature. Secondly, multiple biopsies taken from the vagina and introitus showed the presence of tumor in all biopsied areas regardless of whether or not gross tumor was visible at that point. It was felt that this represented extensive multiple sites of origin and that it would be impossible to evaluate whether or not extension had occurred into the bladder, rectum or vulva. In cases such as these one has only one chance at cure. By the time recurrence becomes noticeable, there is most often distant spread. After considerable discussion, it was decided that preservation of this child's life was more important than the possible sequela of loss of the bladder and rectum. On the other hand, it was decided to preserve the ovaries inasmuch as there is no evidence of specific involvement of the ovaries by sarcoma botyroides nor is there evidence that ovarian function per se is instrumental in the development or the subsequent course of the disease. The preservation of ovarian tissue is extremely important in a child as ovarian function in the future is important in proper maturation of the skeletal system as well as in the development of secondary sexual characteristics. Although these factors could be controlled by exogenous estrogens, it was felt that the normal hormonal function would be easier and less troublesome. Our experience has been that one can preserve ovaries and good ovarian function with otherwise radical surgery.

Probably the most difficult part of this operation was the decision to do it. It has been my experience that adults subjected to procedures such as this adapt quite well for the most part. There are, of course, a few who are never able to adjust to the presence of one or two abnormal stomas for the excretion of urine and feces or the absence of external genitalia. However, it is surprising how quickly most people do adapt. One can only conjecture as to the adaptation of the child. It would seem that such adaptation would be easier in a child as she would more or less grow up with the problem and not suddenly have it thrust upon her in later life. As there has been limited experience with this type of surgery in children, no one has a large enough experience nor long enough follow-up to be able to say definitely whether or not proper adaptation does occur. It was felt that a chance of life, even though somewhat altered, was better than the risk of failure of cure.

It is our plan to follow this child indefinitely, and should the operative procedure prove curative, provide her with an artificial vagina at such time as she plans marriage. The experience with such surgery has been good.[3] Such an artificial vagina allows the patient to fulfill her sexual role, and leaves her lacking only the possibility of pregnancy. Since 10% of all married couples are barren, infertility is not unusual and with the increasing numbers of babies available for adoption, certainly it is not tragic.

Psychiatric Implications

Even before the question can be raised as to the effect of this surgical procedure upon the future personality development of this child, concern has to be directed to the possible future recurrence of the malignancy and the threat to life itself. Such a threat can mean that the child may be raised in an atmosphere of chronic anxiety, fear and guilt leading to overprotection with resulting invalidism.

The child will be conscious of "being different from other children" as a result of this surgery and may possibly perceive herself as being mutilated and deformed as a result of some unknown "badness" on her part or through fate. She may experience a marked disturbance of body image.[4]

Much of her pre-adolescent functioning will depend upon her adjustment to the colostomy, her capacity for self care of excretory functions and to what degree she is able to lead a full and active life. In addition the attitude of her parents, peers, and other adults in her life will contribute to her adjustment.

With adolescence there will be a resurgence of concern about her anatomical deformity and she may question if she is an imperfect female. Her adjustment will depend upon her adaptability and the attitudes of other significant people in her life. These attitudes will largely determine whether she passes through this period unhampered or becomes burdened by a major identity crisis.

Upon reaching womanhood, she may have to face the questions of marriage, the incapac-

ity to bear children, and her limited sexual role. The question may arise as to the benefits which could derive from a surgically created vagina.

This child could develop a normal personality and lead a full and useful life limited only by the incapacity to bear children. However, such fulfillment will depend on her basic ego strength and the support afforded by her parents, peers, and others in her life.

The child is a bright, attractive outgoing normal female. She was born out of wedlock and her care was poor to marginal until the time of her arrival in her present home at the age of 21 months. Formal adoption proceedings had been completed just before the onset of her current illness. The foster mother is ambivalent towards the child, reflecting perhaps her misgivings in adopting a defective child, who would be a considerable burden and might not provide her with the gratification of a healthy child.

In conclusion, it is impossible to predict the personality development of this child, but good preventative medicine dictates that both child and mother be offered psychotherapeutic services.

Sociocultural Implications

The patient's family is lower-middle class and lives in a small town near Pikeville in eastern Kentucky. The predominant cultural values there are those of the Appalachian area. Among the cultural values which will impinge upon the patient as she matures, two are especially important: those about sex, and about disability.

American values about sex are contradictory; a wide variation in actual sex behavior is countenanced, but the general attitude is still puritanical, regarding sexual functions and organs with shame and embarrassment. This attitude is even stronger in Appalachian culture;[5,6,7] for example, the folk term for the genitals is "secrets." So little sex information is provided that many children grow up knowing nothing more about reproduction than the fearsome fact that intercourse leads to pregnancy. Yet it is characteristic that repressive sex attitudes also embody a latent emphasis upon, and enhancement of, sex. Thus a person with deviant sex tastes[8] or one who, like the patient, is sexually handicapped may come to have an exaggerated, emotionally crippling, sense of personal inadequacy or defect. It is thus particularly important that the patient's parents understand the nature of the patient's sex disability (what she has, what she lacks, and the expected normal development of secondary sex characteristics) so they can provide guidance and help her to accept herself as she moves from childhood to adulthood.

It is probable that many in the patient's home community will know that something is wrong with her. Obviously, much depends upon the discretion of her family, but through the participation of the patient in school and play groups, various individuals will find out. The patient and her family may expect that a certain amount of misinformation about her will exist, and that the nature of her difficulty will be misconstrued (the more so, perhaps, because to all outward appearances she is a completely normal female.) Some will misunderstand her disability and, without communicating their misunderstanding (since it concerns very personal matters) treat her as if she were different from the person she is. The very ambiguity and sensitiveness of the situation means that incorrect notions can scarcely be set aright. It is thus all the more important that the patient and her parents have a full understanding of her disability. This understanding should also include some guidelines for the appropriateness of disclosing to others the disability; and it should include the capacity, on their part, to state accurately the nature of the disability to those persons who, in their judgment, should know.

Cultural values about disability will also figure in the patient's emotional development and self-concept.[9,10] Serious physical disabilities, stemming from mine, trucking, lumbering, and household work, are all too prevalent in eastern Kentucky. Along with this, there is an all too common tendency to adopt a passive, fatalistic outlook which ignores the possibilities of restoring the victim to maximum useful function. Similar considerations apply to handicapped children; a blind child, or a child with a speech impediment, will often be regarded as being totally handicapped, and little effort will be made to rehabilitate the child. Such an attitude is of course not universal in the region, but it is widespread and more dominant in lower than middle class contexts. Such a child will typically be overprotected and placed in an enforced dependency position incommen-

surate with his disability. He will be cared for by his parents during their lifetime and thereafter by siblings or other kinfolk.

In the present instance, the patient's disability need not be a gross physical or mental handicap. It is difficult to predict in which (if any) wider category of disability her problem will be classed by others. It would be unfortunate if others regard her as more seriously disabled than she is. While her anatomy is abnormal and she has a colostomy to manage, her physical development should be normal. In terms of emotional development, she is bound to feel "different", but with adequate parental guidance, this need not become an all-pervasive and severely damaging self-concept.

Under the best of circumstances, the patient will face difficult problems at adolescence. She will probably have normal female libido and physique, but child-bearing and intercourse are impossible. The possibilities of a prosthetic or a plastically created vagina deserve consideration. If dating becomes an issue, carrying with it an implied development of intimacy with males, she will need to stake out the terms and boundaries of her participation. Another possibility is that, even without emotional damage or severe personality constriction, the patient will, in the course of growing up with her limitations, decide that the more usual dating relationships and marriage are not for her.

More practically, it appears that the patient has a good chance for a reasonably good life-adjustment, provided that cultural obstacles do not intrude. A program of counseling for the parents should be initiated, helping them to accept the patient as she is, to understand clearly the nature of the disability, and to work out comfortable policies for communicating with others about her. The ideal time for instituting these measures is now, following closely upon the operation and continuing after the patient returns home.

Summary

The holistic approach to patient care is a far reaching concept. The acceptance of a patient as an individual rather than merely as a "disease state" is at times difficult. In the case at hand the decision to operate involved the individual rather than merely the disease. This 2½ year-old child would not always be in a hospital environment. She would eventually return to the society from which she came. She would return as a disfigured child, a child quite different from those around her, a child void of her sexual organs as well as possessing markedly changed excretory channels. The decision to perform such radical surgery on a 2½ year-old child, therefore, had to entail not only the physical implications but also the psychiatric and sociocultural implications of such surgery.

In this paper we have the views of three specialists, each relating his ideas on the future of this child and how surgery will affect this

(Continued on Page 626)

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Ebstein's Anomaly in an Infant With D_1 Trisomy Syndrome

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An infant with multiple congenital anomalies consistent with D_1 trisomy is described. Necropsy revealed in addition to characteristic findings of D_1 trisomy, Ebstein's anomaly. The possible relationship between the chromosomal anomaly and embryogenesis of the cardiac lesion is discussed.

THE CYTOGENETIC and clinical findings in infants with the D_1 (13-15) trisomy syndrome have been described in great detail since its initial description in 1960.[1-3] The purpose of this paper is to report the occurrence of a relatively rare cardiac malformation, Ebstein's anomaly, in an infant with D_1 trisomy.

This white male was admitted to Louisville Children's Hospital at the age of two months because of multiple congenital anomalies. His mother was 45 and his father was 48 years old. There was no history of malformations in the family. Conception occurred during an epidemic of rubella, but virologic studies on postmortem tissues revealed no evidence of rubella infection in the infant.

Anomalies noted clinically included low-set ears, microphthalmia, bilateral cataracts, bilateral palmar creases, an accessory digit on the right hand, rocker-bottom feet, and undescended testes. (Fig. 1) A systolic murmur was noted, as well as X-ray evidence of a markedly enlarged heart.

During hospitalization, the child developed a urinary tract infection, followed by terminal acidosis and intestinal obstruction. He died at four months of age.



FIGURE 1. Infant with D_1 trisomy syndrome

Necropsy confirmed the above abnormalities and also revealed the following additional malformations: absence of the dorsal mesentary, ectopic pancreatic tissue in the pylorus, patent omphalomesenteric duct, accessory spleen in the tail of the pancreas, double left renal pelvis and ureters, and polycystic kidneys.

The cardiac findings at autopsy included a persistent left superior vena cava, an atrial septal defect, and patent ductus arteriosus. The septal leaflet of the tricuspid valve was grossly deformed, small, puckered and appeared to be partially adherent to the ventricular wall; the posterior leaflet was relatively small and not so puckered as the septal leaflet, and both were displaced downwards into the rather dilated right ventricle. The anterior leaflet was located at the annulosus fibrosus, but it was

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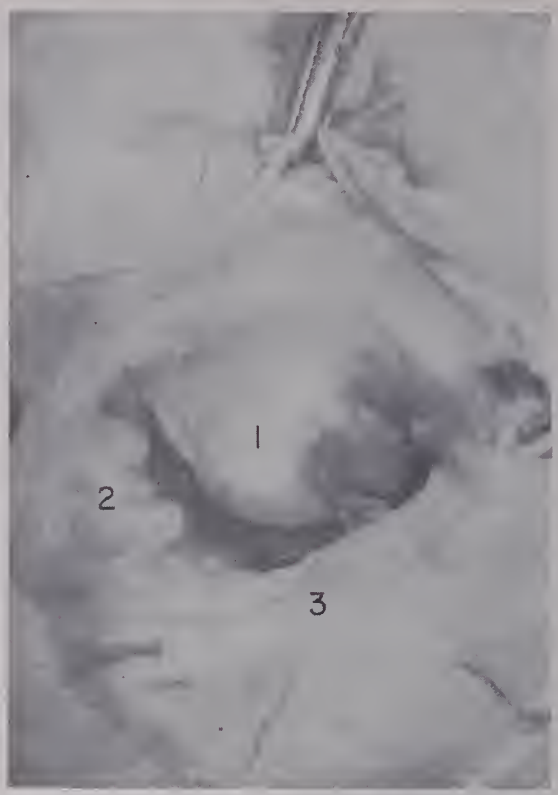


FIGURE 2. (A) Tricuspid valve viewed from the right atrium

(B) The valve viewed from the right ventricle (1) indicates ballooned out anterior leaflet (2) the puckered septal leaflet, and (3) the annulosus fibrosis

unusually large, ballooned out and freely mobile. (Fig 2 A,B).

Chromosome studies performed on peripheral blood leukocytes revealed D_1 (13-15) trisomy. (Fig. 3)

Discussion

The tricuspid valve deformities found in this infant are compatible with the generally accepted characterization of Ebstein's anomaly.[4] The septal (lateral) and posterior leaflets of the tricuspid valve ae usually displaced lower down to the wall of the right ventricle instead of to the annulosus fibrosus, so that atrialisation of a part of the ventricle takes place, while the larger than usual anterior leaflet may retain attachments to the ring. The degree of malattachment and deformities of the valves may vary widely.

The most frequent type of cardiac defect in the D_1 trisomy syndrome is ventricular septal defect, the next most common being dextrorotation of the heart and atrial septal defects.[2] Other cardiovascular anomalies that have been reported include transposition of the great vessels,[5] overriding of the aorta (and pulmonary stenosis)[6] anomalous pulmonary venous drainage[5,7] and tetralogy of Fallot.[8]

The formation of the tricuspid valve leaflets begins at the 11-23 mm. fetal length (5-7 weeks). The inferior or posterior leaflet of the

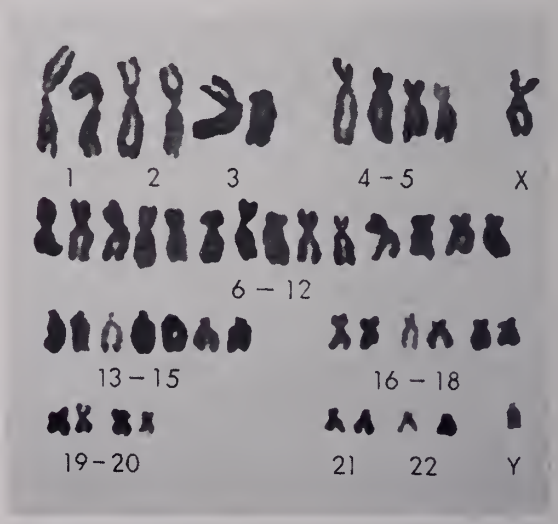


FIGURE 3. Karyotype of cell leukocyte culture, showing D_1 (13-15) trisomy

(Continued on Page 632)



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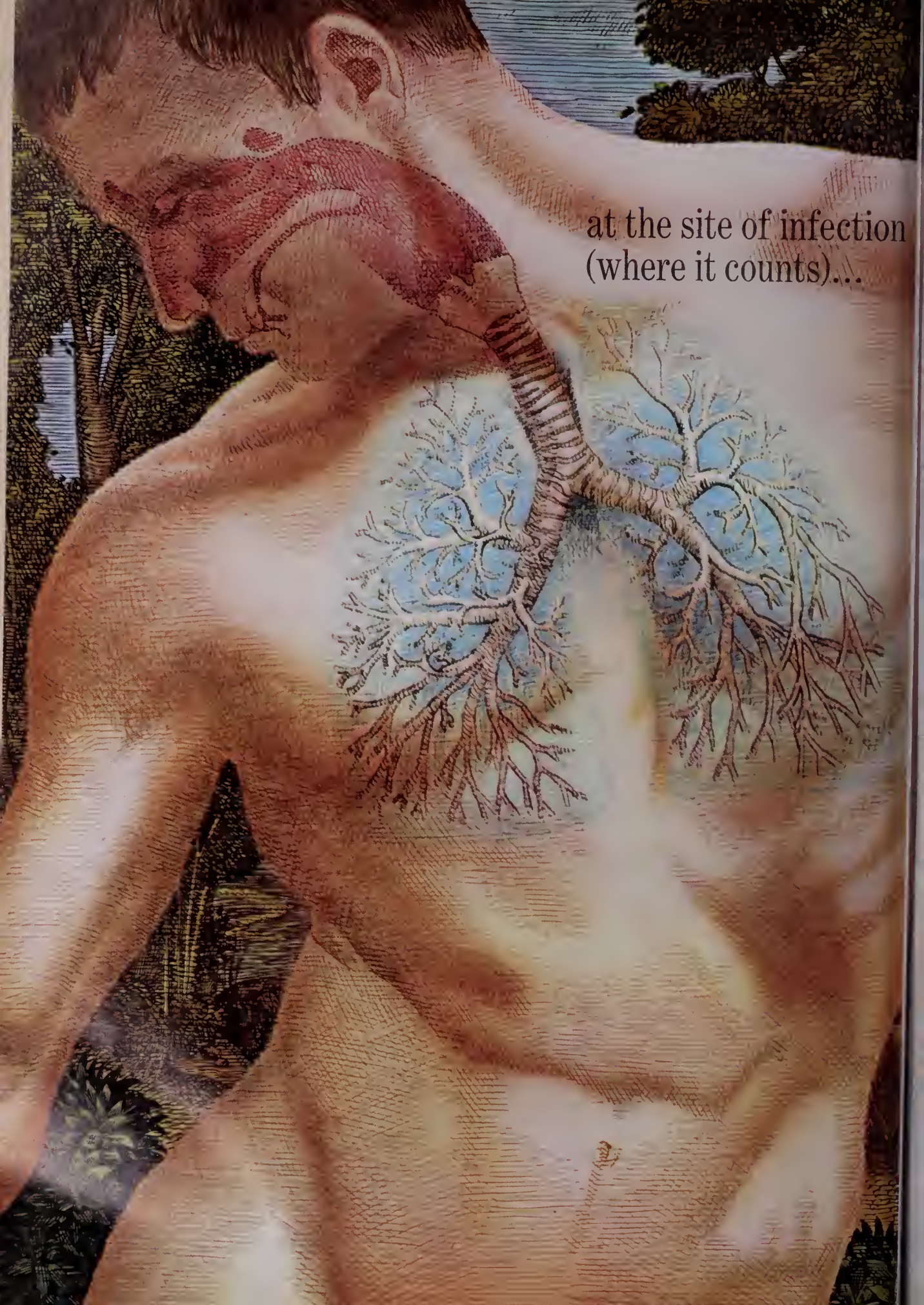
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627-6—3613


at the site of infection
(where it counts)....

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®

Lilly

Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, an mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six month patients with rheumatic fever have taken prophylactic do 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had ep of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mont rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Ele of SGPT and serum alkaline phosphatase levels during the of treatment was observed in one patient treated with I and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the pen group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients were parable to those in a similar control group who had re penicillin.

Gastro-intestinal disturbances not associated with hepa fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with t of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally
Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds o weight, the usual dosage is 5 mg. per pound every six hou children twenty-five to fifty pounds, 125 mg. every six (Tablets Ilosone Chewable should be chewed or crushe swallowed with water.)

For adults and for children over fifty pounds, the usual of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythr therapy should be considered.

In the treatment of syphilis, the recommended total do 20 to 30 Gm. given in divided doses for a period of ten to days. Close follow-up of the patient is necessary since e mycin drugs have not had adequate evaluation in all sta syphilis. Examinations of spinal fluid are recommended a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four da recommended? In the treatment of gonorrhea, patients suspected lesion of syphilis should have a dark-field exami before receiving antibiotics, and monthly serologic tests be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 2 (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equi to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pac

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:6
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:39
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198,

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

SPECIAL ARTICLES

Accuracy in the Clinical Laboratory

GEORGE F. BROCKMAN, M.D.*

RECENT headlines brought to mind the advice Professor John Walker Moore gave a young interne who had missed a diagnosis of typhoid fever on Male Medical White because of an ambiguous leukocytosis reported by the General Hospital Laboratory—"Remember, you're treating the patient, not a laboratory report. If the report doesn't agree with the patient's condition, make them do it over, *and you watch them do it.*"

A Congressional Committee was making the headlines, as a part of Washington's continuing pre-occupation with the practice of medicine, by investigating the need for Federal legislation regulating clinical laboratories. The Committee demonstrated that a dog could get a "certificate" as a laboratory technician, which was hardly news to any physician who has employed a few technicians. Experts dutifully produced other headlines by accounts of mismatched transfusions, and with fantastic guesstimates of the percentages of erroneous laboratory reports in this country annually. While one may cavil at the percentages, there is no doubt that many physicians downgrade their talents by making judgments based on laboratory information of doubtful or no value. Thoughtful and competent workers have documented in the literature pathetic records of inadequate performances in many laboratories, on tests ranging from the I-131 uptake to blood typing. Since these tests are made for medical purposes, the blame for this sorry performance must fall on physicians. In most instances, it is hard to fault John Walker Moore's assessment that it is on the back of the clinician.

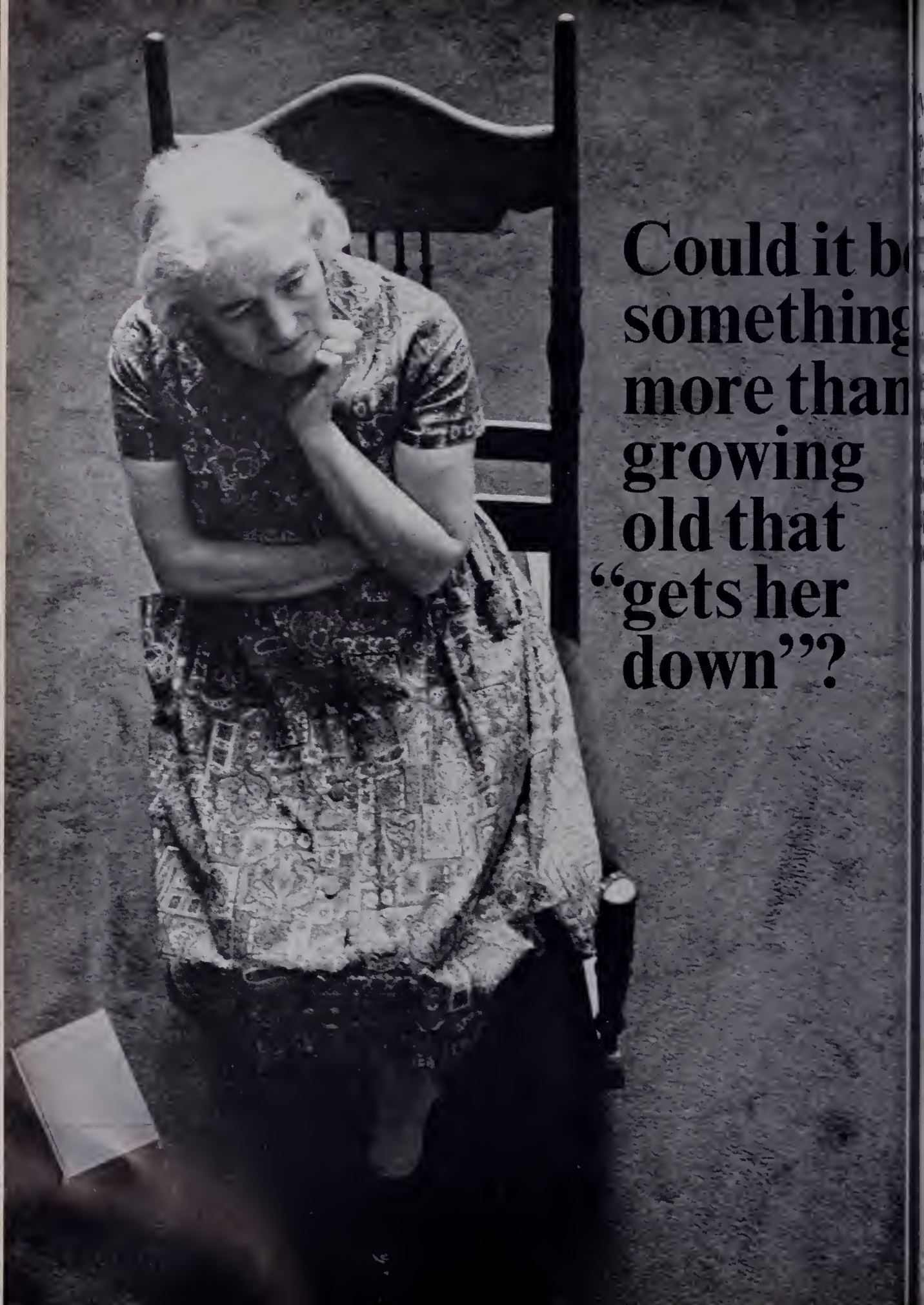
Ideally, every clinician would have the benefit of determinations made under the supervision of a well-trained clinical pathologist, hag-ridden by a complex for perfection. The scarcity of these estimable professionals, and factors of time, geography, economics and convenience mean that not all clinicians are able to delegate their responsibility thus completely. As a substitute, there has developed a tendency to rely on tests performed only by Registrants of the American Society of Clinical Pathology. This is a quick and easy solution to the burdens of bureaucratic responsibility, and has the merit of administrative simplicity. The clinician who is concerned about performance will remember that Registration, like the medical diploma, is a historical document, certifying to an adequate apprenticeship and to at least a minimum standard of competence *at one time*. Since that time, most of the bearers have flourished, but some have drooped and a few have actually withered.

The clinician who is concerned about the value of test reports can do much to improve performance by simple physical inspection of the laboratory that performs his tests. While electronic instrumentation and pre-packaged reagents have eliminated many sources of error, the human element is with us still. Specimens are mis-labeled, and mis-identified, reagents can be improperly preserved and over-age. A thumbprint can be left on a single-use disposable couvette as readily as on a dirty glass one.

Statistical quality control is a sophisticated measure of the cumulative errors that may occur as a specimen is processed. Recognizing

(Continued on Page 632)

Specialist in internal medicine, Greenville; president-elect of the Kentucky Medical Association, and former speaker of the KMA House of Delegates


Could it b
something
more than
growing
old that
"gets her
down"?

Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?

When functional fatigue is part of her problem, Alertonic can help counteract accompanying apathy and inertia. It helps lift mood, stimulate appetite, and establish new interest in daily life.

Pleasant-tasting Alertonic combines pipradrol hydrochloride—a gentle cerebral stimulant—with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Especially in the aging patient, nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding, and encouragement. Between visits, however, your prescription for Alertonic can help keep your patient from giving in to functional fatigue.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals ...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Available only on prescription

Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
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Cincinnati, Ohio 45215

7-8378



Survey of General Practice

JOE Hamburg, M.D. of the department of community medicine of the University of Kentucky Medical School has presented a report of a Pilot Study by his department during the summer of 1966. This work was accomplished by six medical students: S. L. Bower, J. K. Koster, R. F. Long, Jr., C. K. Maffet, W. Sebastian, Jr., and D. M. Hickey. During a six weeks period these men were in the offices of 36 physicians in the state engaged in general practice in widely separated areas. Doctor Hamburg states that the object of this study was to determine the nature of general practice in Kentucky, to detect areas in which medical education of future physicians might be strengthened, to identify post graduate programs which would be of interest to these physicians, and to explore means by which the medical schools of Kentucky could be of greater service to the practicing physician.

The report was based on 3,408 patients seen in physicians' offices and 250 patients seen at their home or hospital. The statistical analysis was limited to patients seen in the office. It is interesting to note that these 36 physicians were provided with what would generally be regarded as adequate office help, generally including receptionist, nurse and laboratory technician. Two thirds of the offices surveyed had x-ray facilities and 86% had laboratory facilities available. Ample space was provided for examination of the patients, the average being 3.6 examining rooms per physician. Among these physicians engaged in general practice a brief but reasonably comprehensive history of the patient's present illness with usual attention paid to the past health and family history was done. There was considerable variation in the extent of the physical examination, but this apparently was tailored to the needs of the patient on each individual visit. At any rate a specific diagnosis or often multiple diagnoses were recorded as a basis for treatment instituted, and this conclusion was supported by reasonable laboratory and x-ray findings in a very large percentage of instances. A list of therapeutic measures used would indicate that care had been taken in prescribing treatment for reasonably well established diagnosis.

Of the patients covered in the survey 3.7% were referred by their examining physician to a specialist for more definitive study. This would suggest that the general practitioner feels the responsibility of assuming the total care of patients in the vast majority of instances.

This initial study affords a very favorable impression as to the medical care that is being received by patients throughout the smaller communities in the state. It is a high compliment to the 36 physicians involved that they were willing to participate in the experiment. It further indicates the diligence with which they pursue their profession and the responsibility which they feel for the health of those who entrust to them their care.

The survey will probably be extended during this and subsequent years and some of the purposes originally set forth in the report will be accomplished.

This experiment has not been an attempt to establish preceptorships of medical students with physicians. This method of teaching has been used rather widely and has much to recommend it. Fred Blankenship, M.D., from the University of Louisville, during the summer

of 1966 carried out a smaller and somewhat different method of survey from the department of preventive medicine at the University of Louisville School of Medicine. Any means that will bring the medical student in direct contact with daily practice and stimulate an awareness of community needs is bound to be helpful and stimulating in his course of study. It is hoped that this method of teaching and liaison between the student and the physician in private practice will be extended, refined and improved to the betterment of all concerned.

SAM A. OVERSTREET, M.D.

The Form of Medical Practice

MOST of us are busy enough in the care of individual patients that we have little time left to contemplate or reflect upon the factors that determine the overall form of medical practice. Circumstances and events affecting our own individual practice are more easily identified than the larger and often more subtle influences on the general nature and manner of medical practice.

Given the desire and time to identify some of the determinants of practice there are a number that many of us would likely agree upon. There is the effect upon the practice of medicine of the research and technical developments that are constantly going on in the medical and related fields. New information, new techniques and new instrumentation constantly mold and change medical practice. This vast supply of new information has been a factor in the well-recognized trend to specialization. It has been a factor in the less dramatic trend to informal and formal group practices. The trend toward hospital centered practice is the result in part of new technical developments and new instrumentation. What of the influences outside of the medical profession? The socio-economic atmosphere in which medicine is practiced will mold the form of that practice. For example, the political mood of the majority of the society will be a factor. The degree and kind of governmental activity influences the form of medical practice. The economic condition of the society is a factor. An affluent society will be spending more money for roads, hospitals and other institutions that influence the form of medicine. The particular form of medical practice at any one time in history is thus the result of the interaction of the technical developments within medicine and the multiplicity of operating factors within the socio-economic environment.

Research into the organization of medical practice has been limited. It is a difficult area in which to set up a well-defined study from which sound conclusions can be drawn. The few studies that have been carried out have frequently been published in journals that the practicing physicians would ordinarily not be exposed to, such as the "Journal of Medical Education" and "American Journal of Public Health."

In February of this year, the President transmitted a message to the Congress concerning health and education. As a part of the message, he directed the Secretary of Health, Education, and Welfare to establish a National Center for Health Services Research and Development. He also recommended an appropriation of twenty million dollars to the Department of Health, Education and Welfare in 1968, for research and development in health services which is nearly twice as much as in 1967.

The Department of Health Care Services of the American Medical Association under the direction of Roy F. Perkins, M. D., is active in several phases of health care research. Last year, the Department studied certain features of the physician's practice patterns and subsequent studies are planned to assess physician productivity, efficiency of varying systems in the delivery of health services, optimum utilization of medical manpower, and related problems. The Department of Hospitals and Medical Facilities is working with the American Hospital Association in assessing the effect of automated procedures and the general use of computers on information retrieval,

medical audits, quality of care, and conservation of manpower. Doctor Perkins indicated recently that some thought was being given to the establishment of a study body and advisory group on health care organization which would have liaison with constituent medical societies in evaluating local health needs and community health programs.

A bill passed in the recent Congress allows the states to receive federal grants to study the health services in the respective states for the purpose of coordinating the various health programs. In 1966, the KMA Board of Trustees authorized a special committee to be named the Committee To Study Health Services in Kentucky. This committee is under the chairmanship of Gabe A. Payne, Jr., M.D. It has been the recommendation of that committee that the State Department of Health should be designated as the Comprehensive State Health Planning Agency under the Comprehensive State Health Planning Act with the advice and assistance of KMA.

By executive order of the Governor, the Department of Health has been designated the agency to serve as the Health Planning Agency to develop policies, procedures, and regulations for comprehensive health planning. The same executive order creates a state-wide Health Planning Council which shall advise and counsel the Department of Health in the administration of the state plan for comprehensive health services including the inventory of existing health services, health facilities, health manpower, and related health needs. It is anticipated that new knowledge regarding the form of medical practice in Kentucky will result from the activities of the new Health Planning Council.

A new committee of KMA, named the Study Committee for Improved Community Health, Irving F. Kanner, M.D., chairman, is planning to make certain studies of the patterns of medical practices in this state. The research initiated and carried on by this committee can have important effects on the future form of medical practices in Kentucky and in other states as well.

WALTER S. COE, M.D.

Make Plans Now

to attend the

KMA Annual Meeting

September 26-28

Convention Center **Louisville**



Guthrie Y. Graves, M.D.

1903-1967

GUTHRIE Y. Graves, M.D., 63, Bowling Green, president of the Kentucky Medical Association from May to September of 1953, died May 10 at the City-County Hospital. Death was attributed to a heart attack.

The Council of the Kentucky Medical Association, now the Board of Trustees, named Doctor Graves, who was district vice-president from the Western Section, president May 21, 1953, in a special election to fill the vacancy created by the death of R. Haynes Barr, M.D., Owensboro. Doctor Graves served until September of that year when he was succeeded by J. Duffy Hancock, M.D., Louisville.

Doctor Graves graduated from the Vanderbilt Medical School in 1925 and completed his surgical training in Edinburg, Scotland. He began his practice as a general surgeon in Bowling Green in 1931 and became co-founder of the Graves-Gilbert Clinic there six years later.

A member of the Postgraduate Committee of the Rural Kentucky Medical Scholarship Fund, Doctor Graves had attended their meeting May 5 at the Association's Headquarters in Louisville. He was a diplomat of the American College of Surgeons and a fellow of the Southeastern Surgical Conference.

Doctor Graves was known to be loyal to his profession and to organized medicine. He had been active in his county Society and served on numerous committees of the Kentucky Medical Association.



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Tandearil®

oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again



3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary

TA-4919 PC

Why these 7 patients wit moderate to severe anxiet may respond better to Mellar

1. The agitated patient.
Anxiety—particularly that beyond range of minor tranquilizers—quently is expressed as gross m restlessness, fidgetiness and purp less movements, and may erupt aggressive behavior. Mellaril is most a specific for those pati whose anxiety follows such a patt





he psychosomatic patient.

family physician is rarely given diagnostic luxury of a classic, book "anxiety state." Most often ıust probe for anxiety masked by nctional disorder—or which exac- tes a somatic problem. Double- d evaluations have demonstrated Mellaril can be a significant ad- t in the treatment of such patients.



he patient under ational stress.

ril helps the patient deal with ses of everyday life. Nonhabitu-, it can be given for extended pe- of time. It does not "separate" atient from practical problems pressures, does not induce eupho- r a fuzziness which can compro- se the ability to cope with reali- es. Rather, it helps the patient move more competently in his daily world by eliminating use- less tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


Bartholin's gland
Periurethral glands
Cervical gland
Flagyl®
brand of
metronidazole
Seminal vesicles
Bladder
Prostate gland

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

Dosage and Administration — In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Destroys Trichomonads Wherever They Are

SEARLE *Research in the Service of Medicine*

Did Dorothy Larson show you her ankles in private? Now she shows them in public.

Your office examination would have confirmed that Mrs. Larson was up to her knees in edema. Her heart was beginning to fail. And her ankles had disappeared under an inch of salty water.

Along with digitalis, you might have prescribed Hygroton. To get rid of the edema. And to keep it from coming back. And you prescribe Hygroton the same way you usually prescribe digitalis: just once a day.

Tablet for tablet, Hygroton is just about the most effective diuretic going. And it costs a fraction of what Mrs. Larson would have to spend for equivalent therapy with short-acting diuretics.

In fact, Hygroton is an awfully nice way to treat the Mrs. Larsons in your practice. Just tell them you can get their ankles back at half price.



Indications. Hypertension and many types of edema involving retention of salt and water.
Contraindications. Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue BUN rises or liver dysfunction is aggravated. El imbalance and potassium depletion may occur special care in cirrhosis or severe ischemic hear



patients receiving corticosteroids, ACTH, or digi-
alt restriction is not recommended.
ffects: Dizziness, weakness, nausea, vomiting,
ılycemia, hyperuricemia, headache, muscle cramps,
postural hypotension, constipation, leukopenia, throm-
bocytopenia, agranulocytosis, impotence, dysuria, tran-
sient myopia, skin reactions, including urticaria and
purpura, epigastric pain, or G I. symptoms after
prolonged administration.

Average Dosage: One tablet (100 mg) with breakfast
daily or every other day.
Availability: Tablets of 100 mg 6524-V(B)
For full details, see prescribing information.

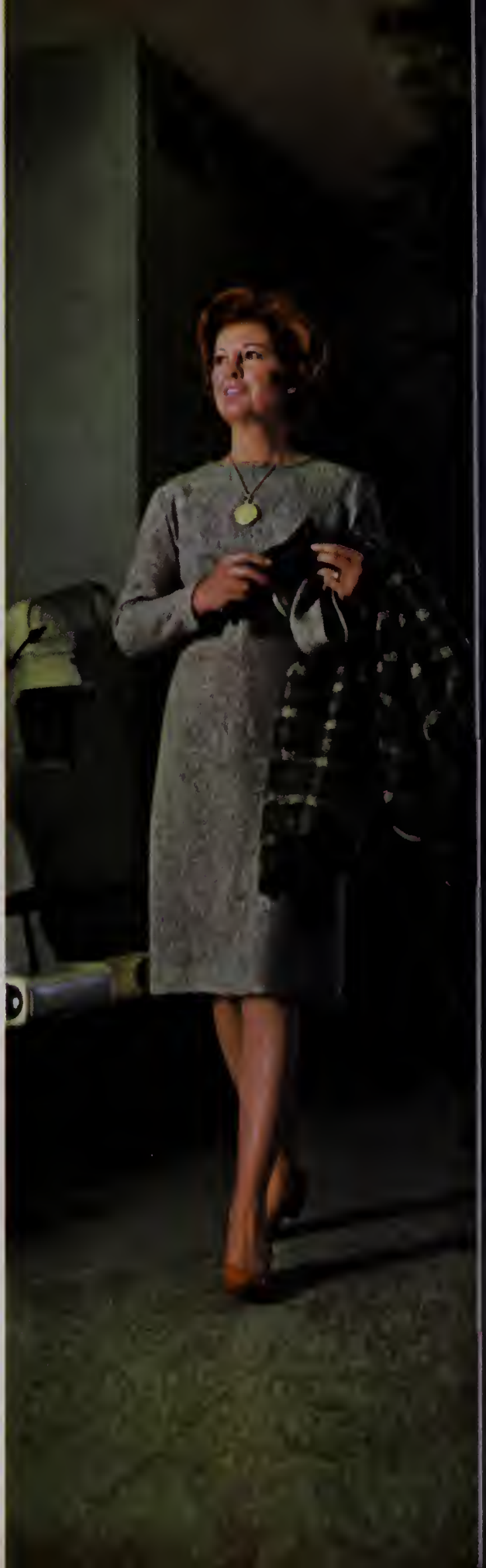
...so you might say Hygroton is good public relations for Mrs. Larson

Because it gets her *out* in public in the first place. At 43, Mrs. Larson worries about appearances and swollen ankles don't help.

But Hygroton's cosmetic effect is only half the story. Hygroton and digitalis therapy helps her get back in the swing of things. Gives her a second wind. Gets rid of the extra pillow she needed for a good night's sleep. Now she even likes to take walks. Just for the fun of it!

When her troubles began, Mrs. Larson thought they were the signs of the change of life. It's a change all right, but one you can treat. And you can count on Hygroton to help keep her in public instead of in the hospital.

See preceding pages for brief summary of prescribing information.



Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

ORGANIZATION SECTION

Therapeutic Abortion Discussions Planned at Annual Meeting

Five prominent medical authorities will discuss various aspects of therapeutic abortions at the September 28 morning session of the 1967 KMA Annual Meeting at Convention Center, Louisville.



Doctor Adelson

Lester Adelson, M.D., Cleveland, Ohio, guest of the Kentucky Society of Pathologists, will speak on "The Forensic Pathologist Looks at Fatal Criminal Abortion." He is chief pathologist and deputy coroner for Cuyahoga County and associate professor of forensic pathology at Western Reserve University School of Medicine.

Doctor Adelson graduated from Tufts College Medical School in 1939. He is the author of numerous published scientific articles and a member of the American Society of Clinical Pathologists, the American Academy of Forensic Sciences, and the American Association of Pathologists and Bacteriologists.

"Psychiatric Implications in Therapeutic Abortions" will be discussed by a Nashville, Tennessee psychiatrist, Nat. T. Winston, Jr., M.D., guest of the Kentucky Psychiatric Association. Doctor Winston graduated from the Vanderbilt University School of Medicine in 1953 and is now serving a second term as Commissioner of Mental Health for Tennessee.

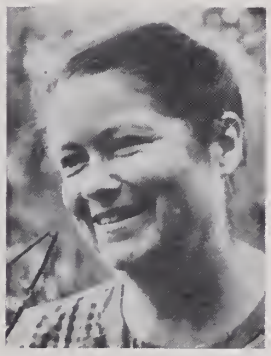
Doctor Winston was the first superintendent of Moccasin Bend Psychiatric Hospital in Chattanooga and while there, he instituted a new program that gained widespread recognition and has been called a "quiet revolution" in the treatment of the mentally ill by one national magazine.

Also participating in the session will be Humbert Riva, M.D., East Orange, New Jersey, guest of the Kentucky Obstetrical and Gynecological Society; Franklin J. Evan, M.D., Corral Gables, Florida, guest of the Kentucky Chapter of the American Academy of General Practice; and KMA member Philip S. Crossen, M.D., Lexington. More information about these speakers will be released as it becomes available.

Immediately following the session on Therapeutic Abortions will be a discussion of birth control entitled "Recent Trends in Family Planning" by Louise Hutchins, M.D., Berea, guest of the Kentucky Association of Public Health Physicians.



Doctor Winston



Doctor Hutchins

Doctor Hutchins graduated from the Yale University School of Medicine in 1936 and during her internship in China, her birthplace, cared for refugee children during the war. Through her work as a member and now president of the Mountain Maternal Health League, she has had widespread contact with many state and regional groups interested in planned parenthood.

1967 Interim Meeting Brings Near Record Attendance

Attendance at the 1967 KMA Interim Meeting April 19 and 20 at Ken-Bar Inn, Gilbertsville, was second highest in its history with 237 registered of which 80 were auxiliary members.

The Board of Trustees of KMA and the Woman's Auxiliary held meetings during the regular sessions. The fourth Orientation Program was presented by the Council on Communications and Public Service.

More than 200 attended the dinner session opening the meeting April 19 to hear an address by Charles B. Shuman, Chicago, president of the American Farm Bureau Federation. Mr. Shuman's speech, entitled "We Are Winning", stressed the necessity for the free enterprise system in medicine and farming.

F. J. L. Blasingame, M.D., Chicago, executive vice-president of the AMA, spoke at the April 20 luncheon session on "A Profession United," outlining the current progress, programs and activities of the AMA.

The April 20 morning session featured three prominent speakers who discussed Blue Shield Plans, physician participation in political activities, and the


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effects of Federal legislation on the medical profession. They were, respectively, Paul I. Hoagland, M.D., president of the National Association of Blue Shield Plans, Williams J. Lewis, Jr., M.D., member of the Ohio Medical Political Action Committee, and John B. Dunbar, D.M.D., assistant dean and coordinator of research for the University of Alabama Medical Center.

Interim Meeting Events

(*See Opposite Page*)

1. **ROBERT E. PENNINGTON, M.D.,** London, KMA president (center), presents checks from AMA-ERF to William R. Willard, M.D., vice-president of the University of Kentucky Medical Center (left), and Donn L. Smith, M.D., dean of the University of Louisville School of Medicine (right) as George F. Brockman, M.D., Greenville, KMA president-elect (far left), and F.J.L. Blasingame, M.D., Chicago, executive vice-president of the AMA (far right), look on.

2. **MEDICINE'S RESPONSIBILITY** in the field of political action was discussed at the Interim Meeting April 20 by William J. Lewis, Jr., M.D., Dayton, Ohio (center). Pictured with Doctor Lewis from left to right are James Imboden, AMPAC field man from Columbus, Ohio, John C. Quertermous, M.D., Murray, new chairman of the KEMPAC Board, Hoyt D. Gardner, M.D., Louisville, secretary-treasurer of the AMPAC Board of Directors, and David B. Stevens, M.D., a member of the KEMPAC Board.

3. **KMA MEMBERS** chat with guests at Ken-Bar Inn, Gilbertsville, where the 1967 Interim Meeting was held April 19 and 20. Pictured from left to right are Robert E. Pennington, M.D., London, KMA president, F.J.L. Blasingame, M.D., Chicago, executive vice-president of the AMA, Robert C. Long, M.D., Louisville, a member of the AMA Board of Trustees, Thomas L. Weisert, R.Ph., president of the Kentucky Pharmaceutical Association, and George F. Brockman, M.D., Greenville, KMA president-elect.

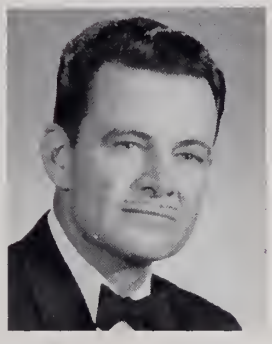
4. **AT THE INTERIM MEETING** the cameraman caught most of KMA's top officers. From left to right are Joseph R. Miller, M.D., Benton, vice chairman of the Board of Trustees, Henry B. Asman, M.D., Louisville, KMA secretary, George F. Brockman, M.D., Greenville, KMA president-elect, Robert E. Pennington, M.D., London, KMA president, Keith P. Smith, M.D., Corbin, KMA treasurer, and Rex E. Hayes, M.D., Glasgow, chairman of the Board of Trustees.

Dr. Farabee To Head KPA

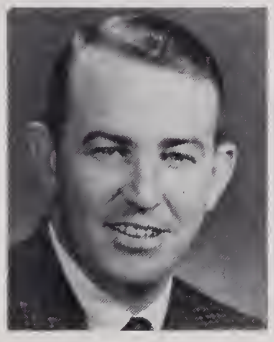
Dale H. Farabee, M.D., Lexington, Kentucky Commissioner of Mental Health, was installed as president of the Kentucky Psychiatric Association at the Association's spring meeting April 27. He succeeds Harvey R. St. Clair, M.D., Louisville.

Dr. Quertermous Elected Chairman of KEMPAC Board of Directors

The new KEMPAC Board of Directors elected John C. Quertermous, M.D., Murray, to the office



Doctor Quertermous



Doctor Barton

of chairman at a May 3 meeting in Louisville. The KEMPAC Board was named by the KMA Board of Trustees during the Interim Meeting in April.

Doctor Quertermous is currently serving as a delegate of KMA to the AMA and is a past president of the Calloway County Medical Society. As chairman of the KEMPAC Board he succeeds Harold B. Barton, M.D., Corbin. Doctor Barton served as chairman of the KEMPAC Board for two years.

Fred C. Rainey, M.D., Elizabethtown, was elected a member of the Executive Committee at the May 3 meeting. He succeeds Daryl C. Harvey, M.D., Glasgow. The Board elected C. Kenneth Peters, M.D., Louisville, secretary-treasurer. Doctor Peters succeeds Richard F. Greathouse, M.D., Louisville.

The Publications Committee reported at the meeting that the descriptive KEMPAC brochure is presently being revised and updated. Plans were made for Kentucky representation at the annual AMPAC Workshop June 3 and 4 in Washington, D.C., where the KEMPAC Kuties of Corbin were scheduled to entertain.

13th Trustee District Plans July 5 Mtg. in Ashland

The Thirteenth KMA Trustee District plans to hold its annual meeting July 5 in Ashland, according to Walter L. Cawood, M.D., Ashland, trustee for the district.

Robert E. Pennington, M.D., London, KMA president, will be the guest speaker at the dinner.

Personal invitations will be sent to all of the members of the District in advance of the meeting outlining further details.

Correction

The Journal of KMA regrets an error which appeared in the article "Twenty-nine Physicians Added to KMA Membership" on page 517 of the May, 1967 issue. John P. Blackburn, M.D., Bowling Green, who is practicing in association with Richard F. Grise, M.D., is the new member and not John P. Blackerby as printed.

Optimil 30

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THE OPTIMUM-NUTRITION INFANT FORMULA

OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.[1-5]

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.[6] (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.[7-9]

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: ibid. 9. Nichols, M.: ibid.



Optimil, the first optimum-nutrition infant formula

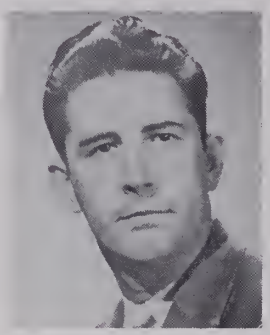
from a world leader in nutritional research... Carnation®

KAGP Elects Dr. Prewitt; Honors Dr. Bryant

The Kentucky Academy of General Practice named Elmer G. Prewitt, M.D., Corbin, president-



Doctor Bryant



Doctor Prewitt

elect and selected Charles G. Bryant, M.D., Louisville, Citizen-Doctor of the Year in Kentucky at its 16th annual assembly May 10 and 11 in Louisville.

Doctor Prewitt will succeed Thornton E. Bryan, M.D., Cadiz, who took office during the meeting. Doctor Prewitt graduated from the University of Louisville School of Medicine in 1955 and is presently serving as secretary-treasurer of the Whitley County Medical Society.

Doctor Bryant, a former president of KAGP, was general chairman for its 1967 meeting. He graduated from the University of Louisville School of Medicine in 1937. Doctor Bryant is active in the Jefferson County Medical Society and an alternate delegate of KMA to the AMA.

Two features of the assembly were a luncheon address by columnist Art Buchwald and entertainment by the Browning Family at the annual dinner.

KMA Fee Survey Chairman Makes Progress Report

The following is a report of the KMA Advisory Committee for Fee Survey that was provided for under Resolution A as passed by the House of Delegates in September, 1966. Roy H. Moore, Jr., M.D., Louisville, chairman, submitted this report which includes figures to May 18, 1967.

The physicians and oral surgeons of Kentucky are to be commended for their response to the KMA—Blue Shield Confidential Fee Survey. By the time this report appears in the June issue of the Journal, Kentucky Blue Shield will have developed confidential fee studies to reflect the high, low, average, median, and predominant fees for procedures and services surveyed.

Meetings of the KMA Governmental Medical Contracts Committee and KMA Technical Advisory Committee for Medical Assistance will have been held on June 7 and 8 with representatives of the appropriate agencies to explore the feasibility of professional fees being paid on a usual and customary fee basis.

The following is an account of survey response:

2810—Surveys mailed to licensed physicians and oral surgeons(32).

—556—Doctors were identified as retired or inactive(116), deceased(22), left state(117), in military(13), not in private practice(207), residents(81).

2254—Approximate number of doctors in private practice.

1471—Total surveys received or on file for studies or 65.3% of 2254.

16—Completed surveys received without name (not included).

26—Total surveys received or on file for oral surgeons or 81% of 32.

105—Counties are represented in survey.

15—Counties having 1 to 5 practicing doctors are not represented in survey.

120—Total counties.

17—Counties having 1 to 5 practicing doctors submitted surveys 100%.

56—Counties having 1 to 71 practicing doctors submitted surveys 50% or more.

14th Trustee District To Meet July 6 in Pikeville

The Fourteenth KMA Trustee District will hold its annual meeting at 6 p.m., July 6, at the Green Meadows Country Club, Pikeville, according to Ballard W. Cassady, Pikeville, trustee for the district.

Robert E. Pennington, M.D., London, KMA president, will be the featured speaker at the meeting. Max P. Jones, M.D., president of the Pike County Medical Society, will preside.

A scientific program preceding the meeting is planned at 4 p.m. At that time there will also be a meeting and program for the women.

15th Trustee District Makes Tentative Meeting Plans

The Fifteenth KMA Trustee District had made tentative plans at press time to hold its annual meeting July 12 at the Mountain-Aire Motel outside Harlan, according to E. C. Seeley, M.D., London, trustee for the district. Members in the district will receive personal invitations containing additional information.

KMA President Robert E. Pennington, M.D., London, will be the featured speaker at the meeting. A scientific program is also being planned.

James K. Hurlocker, M.D., secretary of the Harlan County Medical Society, will be the local chairman for the meeting.

Dr. Hancock Named Pres.-Elect of Kentucky Chapter ACS

J. Duffy Hancock, M.D., Louisville, was named president-elect of the Kentucky Chapter of the American College of Surgeons and Richard Grise, M.D., Bowling Green, was installed as president at the April 28-29 meeting of the Chapter at Stouffer's Inn, Louisville.



Doctor Hancock

Doctor Hancock has served as president of the Kentucky Medical Association and the Jefferson County Medical Society. Doctor Grise succeeds Laurence M. Quill, M.D., Newport, as president of the Chapter.

David Hull, M.D., Lexington, was re-elected secretary-treasurer. New council members are Doctor Quill and John T. Glenn, M.D., Russellville. Both were elected to three-year terms.

Ben Eiseman, M.D., chairman of the department of surgery at the University of Kentucky Medical Center, gave a farewell address to the Chapter. Doctor Eiseman came to the University six years ago from Denver and plans to return to that city.

Also speaking at the meeting was James W. Harkess, M.D., first occupant of the newly established Kosair Chair of orthopedic surgery at the University of Louisville School of Medicine.

A discussion was held at the meeting on the new Regional Burn Center at the University of Cincinnati School of Medicine. The Center, which is sponsored by the Shriners, is said to be one of the most up-to-date of its kind.

Conference of Presidents Set June 17 in Atlantic City

The Conference of Presidents and Officers will hold its annual meeting at 2 p.m. Saturday, June 17, in the Pennsylvania Room at Haddon Hall in Atlantic City.

A discussion of "Who Really Runs Washington" by a panel of outstanding personalities will be one of the features of the program. In addition, Paul Harvey, well-known radio broadcaster, will be one of the principal speakers.

According to James A. Waggener, secretary and treasurer of the Conference, all Kentucky doctors are cordially invited to attend this Conference.

Willard R. Dill, M.D., Danville, has joined the staff of Kentucky State Hospital, near Danville, and is serving as the physician in charge of admissions. Doctor Dill, a native of Asbury Park, N.J., graduated from the University of Louisville School of Medicine in 1950 and recently completed his residency training in psychiatry at General Hospital in Louisville.

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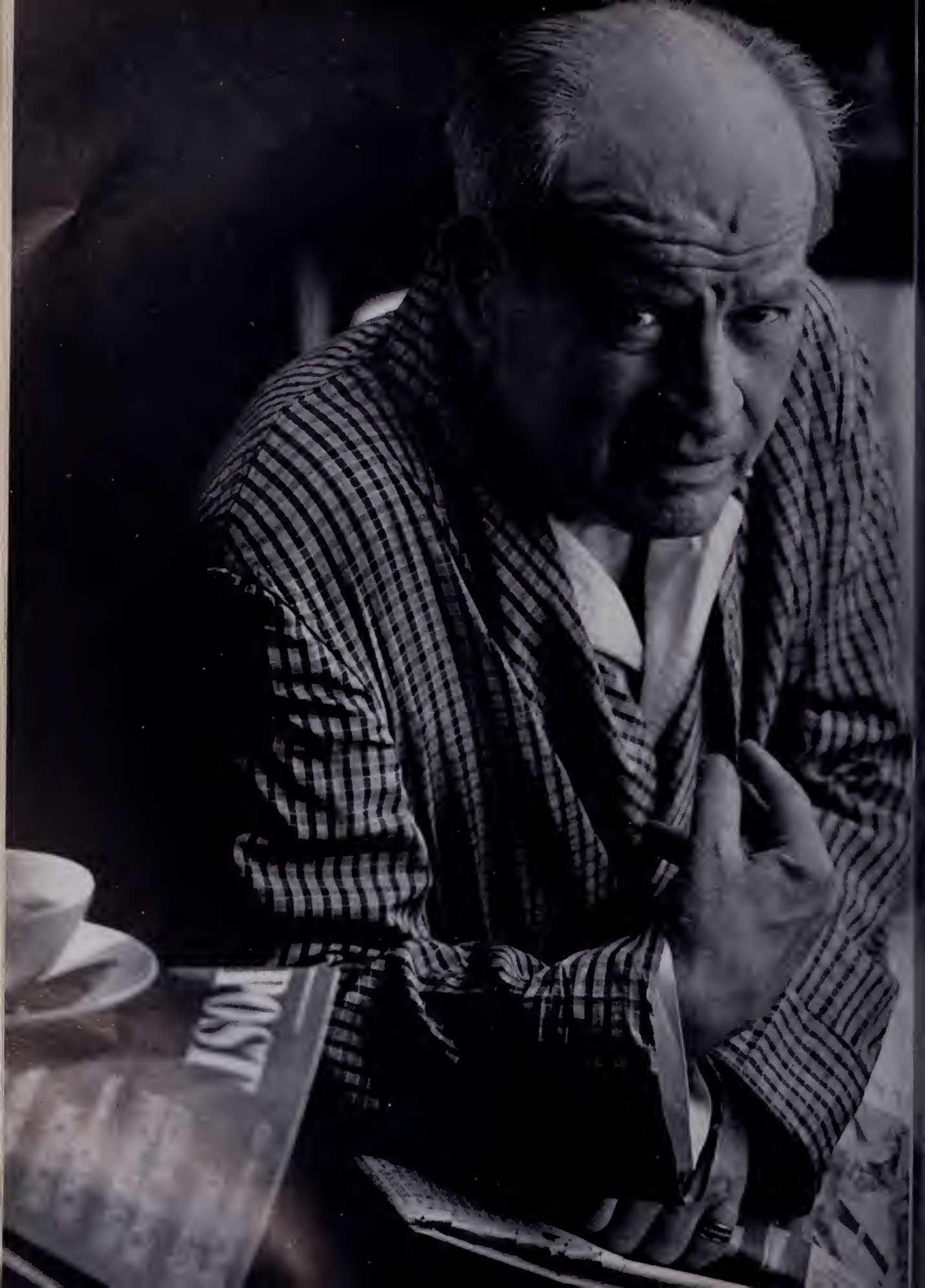
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POST



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I'm supposed to get up and do things?

With my heart?

It's entirely natural—and may even be desirable—for the cardiovascular patient to be somewhat anxious about himself.

But when anxiety leads to unreasonable self-imposed limitations and restrictions . . . when it aggravates cardiovascular symptoms . . . when it interferes with restful sleep, measures to help alleviate the anxiety are probably in order.

One measure, of course, is reassurance. Another, adjunctive measure, is EQUANIL (meprobamate).

Over a decade of experience has shown that EQUANIL (meprobamate) is generally well tolerated as well as effective. Side effects are usually limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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to help relieve anxiety and tension occurring alone or secondary to organic disease

Equanil® (meprobamate)

Wyeth® SERVICE TO MEDICINE



when he just can't slee

Tuina

Sodium Amobarbital an
Sodium Secobarbita

(One-Half Sodium Amobarbital and One-Half Sodium Secobarbit



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal, comprised of equal parts of Seconal® Sodium (sodium secobarbital, Lilly) and Amytal® Sodium (sodium amobarbital, Lilly), is indicated for prompt and moderately long-acting hypnosis.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



Dosage: 1½ to 3 grains at bedtime.

Supplied: ¾, 1½, and 3-grain Pulvules®.

Additional information available to physicians upon request.
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Scholarship Fund Awards Loans To 11 Medical Students

The Board of Trustees of the Rural Kentucky Medical Scholarship Fund approved loans for 11 first-year medical students at its May 5 meeting, according to C. C. Howard, M.D., Glasgow, Board chairman.

Four of the loan recipients plan to practice in "critical" counties. They are Charles Glyndon Click and Charles Edward Crase, both of Berea; Rodney Kent Bates, Hazard; and Glenn R. Womack, Louisville.

Recipients of regular first-year loans are J. Greg Arterburn, Wickliffe; Michael Garrett Carroll, Cave City; Andrew Robertson Hamon, Grayson; Mrs. Victor (Flora) Johnson, Berea; Marvin N. Martin, Eddyville; Warren Grady Stumbo, McDowell; and John William Sutherland, Prestonsburg.

Fifteen renewal applications of upper classmen were also approved at the Board meeting, Doctor Howard said. The Board approved a new team concept whereby the Fund will grant a $2,000 loan to a two-physician team planning to practice in approved areas where the ratio is less than one physician to 6,000 inhabitants.

Doctor Howard expressed his appreciation for the continued interest and support of Governor Edward Breathitt, Health Commissioner Russell Teague, and the Kentucky General Assembly.



The KMA Placement Service and the Rural Kentucky Medical Scholarship Fund cooperated in securing the services of Raymond D. Wells, M.D., Prestonsburg, for the Inez Medical Clinic shown at the time of its dedication April 22. Doctor Wells, a 1965 graduate of the University of Kentucky College of Medicine, will repay a loan from the Fund by serving in Martin County, where for a number of years John W. Ford, M.D. was the only physician serving a population of more than 10,000.

Dr. Willard Appointed Chairman Of National Committee

Surgeon General William H. Stewart recently announced the appointment of William R. Willard, M.D., vice-president for the Medical Center of the University of Kentucky, as chairman of the Program Review Committee for the Nurse Training Act of 1964.

The Committee will make recommendations to the Surgeon General on the continuation, expansion, or other modification of grant programs authorized by the Nurse Training Act. Members of the Committee were chosen from leaders in medicine, nursing, hospital administration, education, and public affairs throughout the United States.

Doctor Willard previously served the Public Health Service as a member of the Surgeon General's Consultant Group on Nursing and as chairman of the 1963 National Conference on Public Health Training.

Kentucky Hospital Association Elects Mr. Meriwether

Richard E. Meriwether, administrator of Muhlenberg Community Hospital, Greenville, was named president-elect of the Kentucky Hospital Association at its 38th Annual Convention April 24-27 in Louisville. Meriwether served four years as director of hospital administration in the Kentucky Department of Mental Health before moving to Greenville in 1965 to administer the 75-bed hospital.



Mr. Meriwether

John C. Pratt, Lexington, assumed the office of president at the meeting. He is the administrator of Good Samaritan Hospital and will serve as president of the Association for one year.

Elected to the 11-member Board of Trustees were Sister Louis Mary, Louisville, administrator of St. Joseph Infirmary; Sister Joseph Ellen, London, administrator of Marymount Hospital; and Robert G. Wilson, Murray, administrator of the Murray-Calloway County Hospital.

H. L. Dobbs, Louisville, executive director of the Hospital Commission of Kentucky Baptists, received the Distinguished Service Award, the Association's highest recognition for outstanding service and achievement in the health care field. Dobbs, sixth recipient of the award, was honored in a special ceremony at the Association's annual dinner meeting.

More than 1500 registered for the four-day meeting which included three general discussion sessions and two informal forums. Edward C. Rosenow, Jr.,M.D., director of the department of hospitals and medical facilities of the American Medical Association, spoke during the convention.

Comm. on Aging Elects Dr. Oliver

Earl P. Oliver, M.D., Scottsville, was elected chairman of the Kentucky Commission on Aging at its March meeting. J. Duffy Hancock, M.D., Louisville, is presently serving as chairman of the Commission's Subcommittee on Health.

The Commission is currently encouraging and aiding in the formation of Senior Citizens Organizations throughout the state, according to Doctor Oliver. The Commission is also sponsoring and helping to finance other projects to promote the health and welfare of older Kentucky citizens, Doctor Oliver said.

Mrs. Applegate Installed Pres. Of Ky. Assn. of Med. Assts.

Mrs. Virginia Applegate, Louisville, was installed as president of the Kentucky State Association of Medical Assistants during its Fifth Annual Convention at Park Mammoth Resort, Park City, May 13 and 14. Mrs. Applegate succeeds Miss Tina Gates, Louisville.

The installation ceremony was conducted by Mrs. Marie Young, trustee of the American Association of Medical Assistants. Other officers include Mrs. Jane Burks, Elizabethtown, president-elect; Mrs. Marilyn Seebert, Louisville, vice-president; Mrs. Sarah Hall, Louisville, recording secretary; and Mrs. Linda Shumate, Louisville, treasurer. New directors are Mrs. Sue Vowels, Elizabethtown, and Miss Libby Curtsinger, Louisville.

Seventy-nine members and guests attended the educational seminar and banquet. Guest speakers were Herbert P. Hargett, M.D., Jeffersonville, Indiana; Jacqueline Noonan, M.D., Lexington; Thomas J. Ferriell, M.D., Elizabethtown; and Avil L. McKinney, Louisville.

John T. Teegen, M.D., left the Denham Medical Clinic in Maysville, April 15, to join the National Aeronautics and Space Administration at Cape Kennedy, Florida. He will be one of three physicians to work with the astronauts at the launch site.



MRS. VIRGINIA APPLEGATE, left, meets with past presidents of the Kentucky State Association of Medical Assistants at Park Mammoth Resort where she was installed as president during the Association's Fifth Annual Convention May 13 and 14. Pictured with Mrs. Applegate from left to right are Mrs. Louise Hawkins, first KSAMA president (1961), Mrs. Wanda Taylor (1965), and Miss Tina Gates (1966).

Governor Reappoints 2 Physicians

Governor Edward T. Breathitt recently issued an executive order appointing George P. Archer, M.D., Prestonsburg, and Sam A. Overstreet, M.D., Louisville, to their second four-year terms as members of the State Board of Health.

The Board of Trustees of the Kentucky Medical Association nominated Doctor Archer and Doctor Overstreet for the appointments at a December 7, 1966, meeting.

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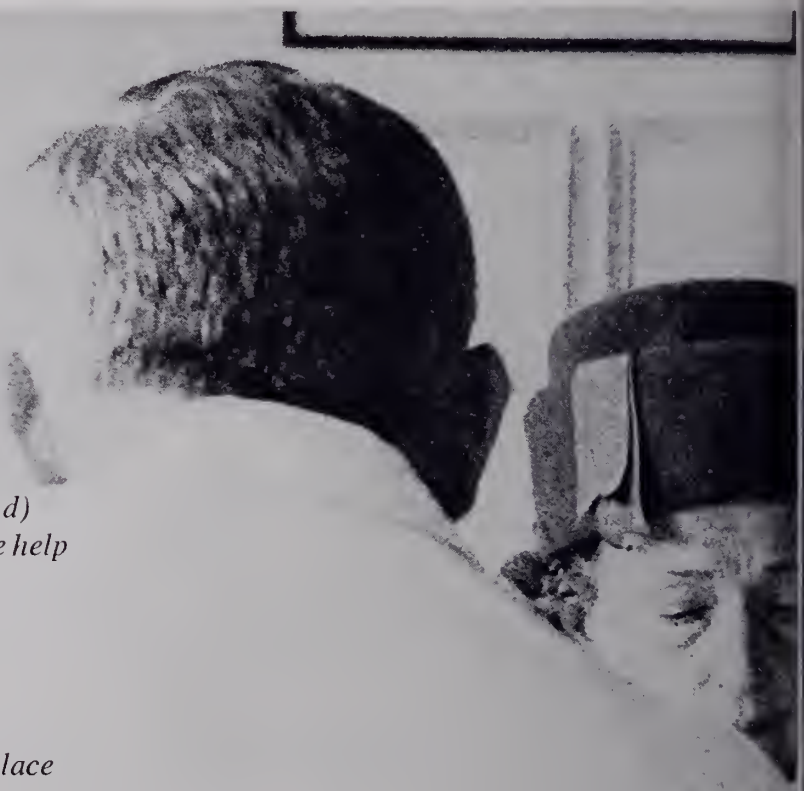
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McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
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*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

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In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

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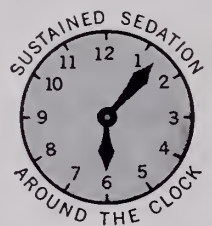
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Henderson Co. Medical Society Celebrates Centennial

The Henderson County Medical Society celebrated its 100th birthday at a dinner meeting May 13 in Henderson. Approximately 80 doctors, their wives and guests from Henderson and surrounding towns attended the meeting which was conducted by Molloy G. Veal II, M.D., Society president.

Eugene Conner, M.D., Louisville, KMA historian, was the guest speaker at the dinner. Arrangements were made by Walter L. O'Nan, M.D., a past chairman of the KMA Board of Trustees.

A citation was given to J. Leland Tanner, M.D., a member of the Society, for years of distinguished service to the community.

10th KMA Trustee District Meets in Lexington

The Tenth Trustee District of the Kentucky Medical Association met in conjunction with the regular monthly meeting of the Fayette County Medical Society March 9 in the Auditorium at Good Samaritan Hospital, Lexington.

Robert E. Pennington, M.D., London, KMA president, spoke to Fayette, Woodford and Jessamine County physicians on "What Do I Get for My KMA Dues?" He described the role, function and growth of KMA in the past and presented impressive statistics on the increasing number of meetings and physician hours involved in traveling to them.

Doctor Pennington also pointed out the vital role of the physician in organized medicine and the necessity of continued support of medical societies at all levels.

Carl Cooper, M.D., Bedford, discussed moral and monetary support of local legislators. He emphasized that "if you wish legislators to pursue certain programs, then you must open your mouth as well as your pocketbook."

He pointed out the vast financial and educational campaigns carried on by the cults and their effectiveness. Doctor Cooper stressed that increasing numbers of physicians must become interested in local, state and national political campaigns.

Dr. Greene Named President of 6th Trustee District

The Sixth KMA Trustee District elected A. W. Greene, M.D., Franklin, president at its annual meeting May 4 in Glasgow. He succeeds Paul J. Parks, M.D., Bowling Green.

Other officers elected at the meeting are Eugene L. Marion, M.D., Glasgow, vice-president, and Rex E. Hayes, M.D., Glasgow, secretary. Doctor Hayes presided at the meeting.

Robert E. Pennington, M.D., London, president of KMA, was the featured speaker at the meeting. He presented a talk on "What Do I Get for My KMA Dues?" Harold B. Barton, M.D., Corbin, talked to the group about the activities of KEMPAC.

12th Dist. Has Scientific Prog.

Members of the Twelfth KMA Trustee District attending the annual meeting May 3 in Somerset heard an address by KMA President Robert E. Pennington, M.D., London, and two scientific presentations.

Doctor Pennington discussed "What Do I Get for My KMA Dues?" The scientific portion of the program was presented by Coleman C. Johnson, M.D., and David H. Johnson, M.D., both of Lexington.

Dr. O'Nan Named Ind. Assn. Pres.

Walter L. O'Nan, M.D., Henderson, was elected president of the Kentucky Industrial Medical Association at an April 22 meeting at Admiral Ben Bow Inn, Louisville. The meeting was held jointly with the Industrial Section of the Registered Nurses Association.

Other officers elected were Herman Pocock, Jr., M.D., president-elect; Randolph Scheen, M.D., vice-president; and Paul Keeney, M.D., secretary-treasurer. All are from Louisville.

Dixon Appointed to HEW Post

Raymond F. Dixon, former Deputy State Health Commissioner for Administrative Services and assistant secretary of KMA, has been named Director of the new Division of Health Manpower Educational Services, U.S. Public Health Services of the Department of Health, Education and Welfare, Arlington, Virginia.

Dixon, the brother-in-law of Bruce Underwood, M.D., former Health Commissioner and KMA secretary, served in Kentucky from 1949 to 1956.

KMA Council and Committee Reports

McDowell House Board of Managers

Laman A. Gray, M.D., Louisville, Chairman

McDowell House
Danville, Kentucky — April 5, 1967

The McDowell House Board of Managers, at their second meeting of this Associational Year, adopted a program authorizing nationwide memberships to the McDowell House. Initial mailings requesting such memberships will be sent to members of the American College of Obstetrics and Gynecology residing in certain sections of the country.

The Board of Managers made plans for future maintenance of the House and grounds and authorized exhibits of the McDowell House at the Annual Meeting of the KAGP, the American Pharmaceutical Association and the home office of the American College of Surgeons during the summer months. The next meeting of the Board will be held during the summer.

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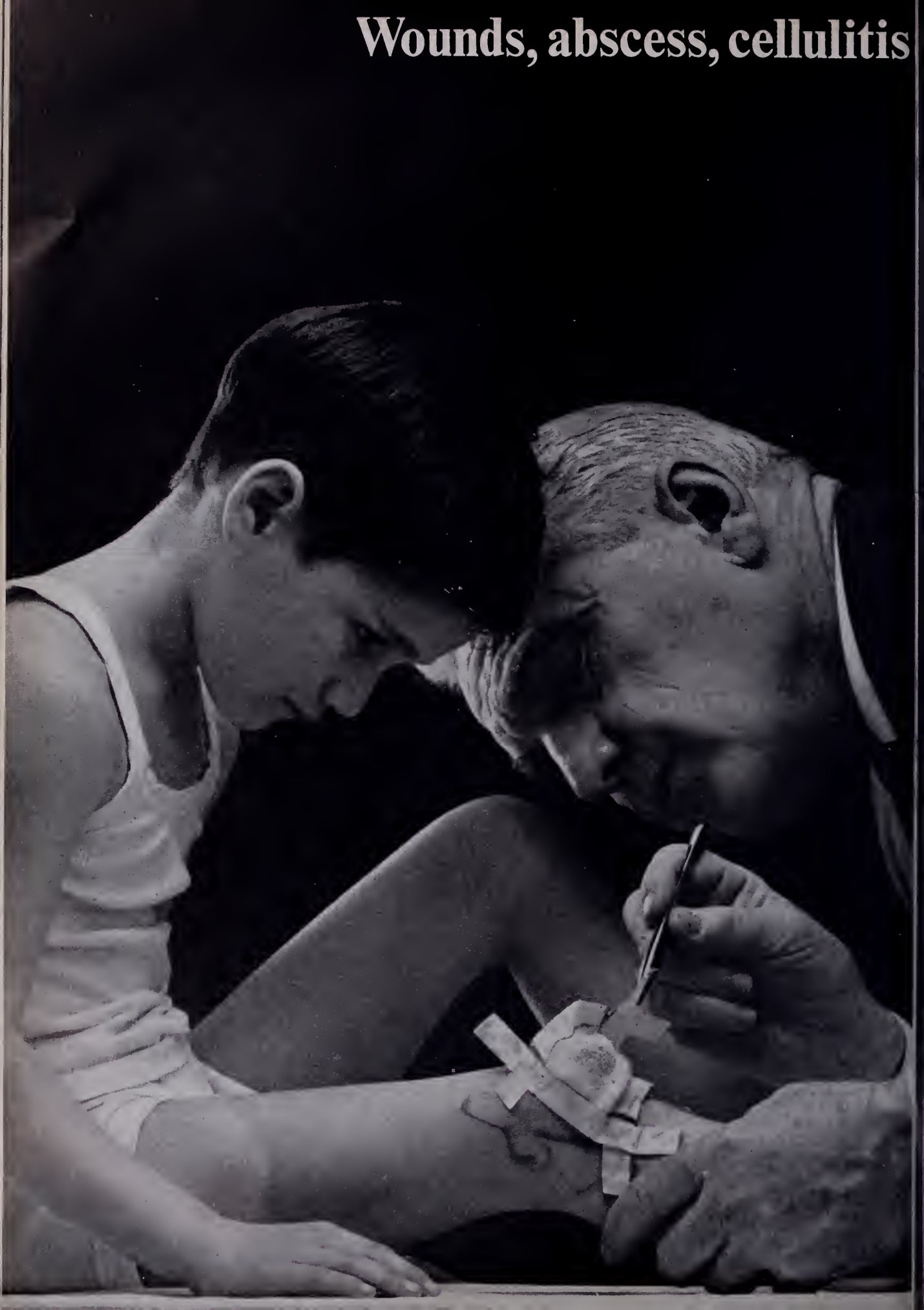
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There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

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Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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In Memoriam

EDWIN C. CAMERON, M.D.
Stanton
1899-1967

Edwin C. Cameron, M.D., 68, county health officer for Wolfe, Menifee and Powell counties, died suddenly April 7 at his home. Doctor Cameron, a native of Canada, graduated from the Dalhousie University Faculty of Medicine, Nova Scotia, in 1927. He had been associated with the World Health Organization in India and professor of preventive medicine at Syrian University in Damascus.

HAROLD GORDON, M.D.
Louisville
1894-1967

Harold Gordon, M.D., 72, a retired pathologist, died April 19 at St. Joseph Infirmary in Louisville. Doctor Gordon, a nationally known contributor to the study of pathology, was a native of Edinburgh, Scotland. He graduated from the University of Toronto Faculty of Medicine in 1922 and served as chief pathologist at SS. Mary and Elizabeth, Veterans and Hazelwood Hospitals.

BENJAMIN F. REYNOLDS, M.D.
Carlisle
1880-1967

Benjamin F. Reynolds, M.D., 87, a Nicholas County physician for 50 years, died April 10 at Good Samaritan Hospital, Lexington. Doctor Reynolds graduated from the University of Louisville School of Medicine in 1903 and served as county health officer for more than 20 years.

BENJAMIN F. WORKMAN, M.D.
Brooksville
1888-1967

Benjamin F. Workman, M.D., 78, a retired Brooksville physician who had practiced more than 50 years in Bracken County, died April 17 at his home. Death was attributed to a heart attack. Doctor Workman graduated from the University of Louisville Medical College in 1910. He was a member of the Northern Kentucky Medical Association and the Bracken County Board of Health.

ARH Board Elects Publisher

Maurice K. Henry, publisher of the Middlesboro Daily News, was recently elected chairman of the board of trustees of Appalachian Regional Hospitals which operates nine community hospitals in Eastern Kentucky, Virginia and West Virginia. Henry succeeds former Kentucky governor, Bert T. Combs.

1967 JAMA Book Now Available

The 1967 JAMA SELECTED QUESTIONS AND ANSWERS paperback book published by the American Medical Association is now available. The questions and answers, covering a large number of medical topics, were selected from 1966 issues of The Journal of the AMA. The 360-page volume may be purchased for $2.00 from the AMA, 535 N. Dearborn, Chicago, Ill. 60610.

The Surgical Psychiatric and Sociocultural

(Continued from Page 584)

future. Although each differed in the approach to his decision, all three came to the same conclusion. All have agreed that this child can lead a successful life, but that success is dependent on adaptation, a mechanism which permits man to adjust even under the most unusual circumstances.

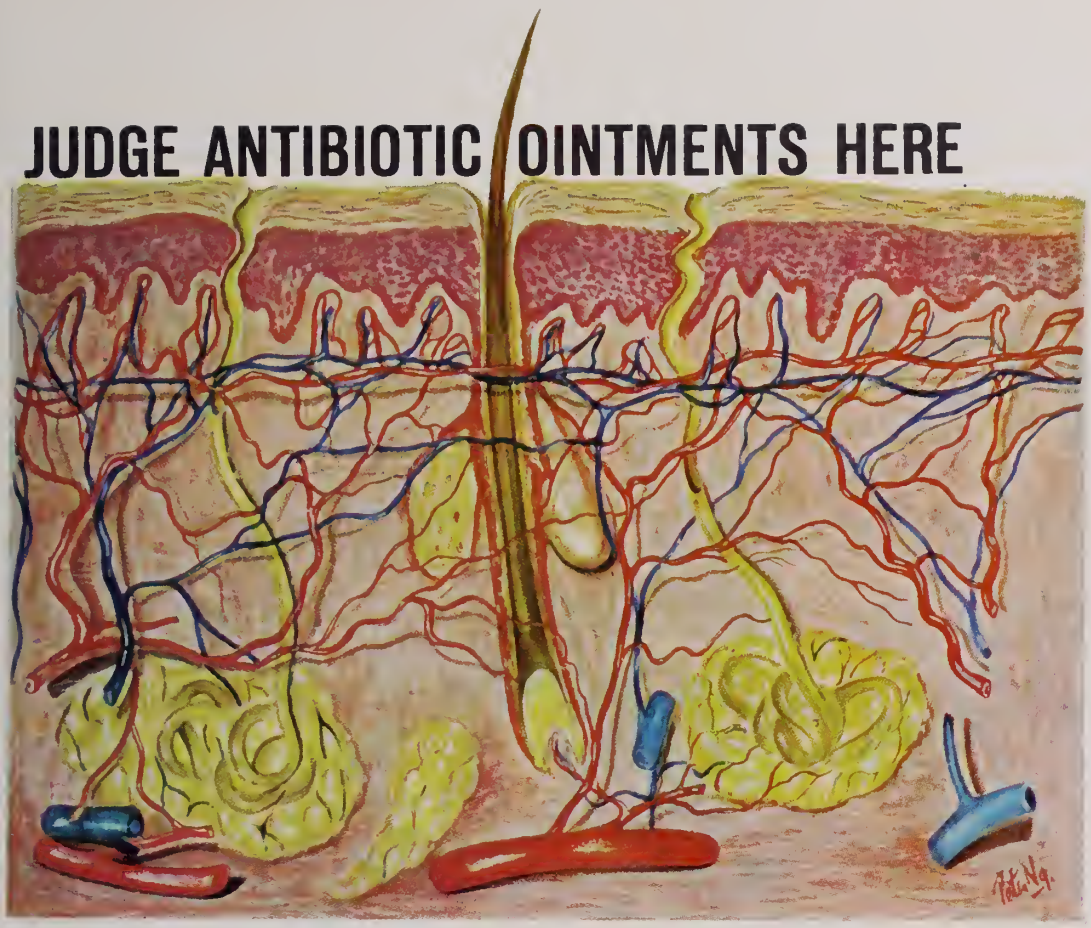
We have tried to demonstrate the importance of thinking of the patient in more than just medical terms. We have used this case history to show that with our new medical technology and knowledge we may be producing, at times, more problems than we are solving.

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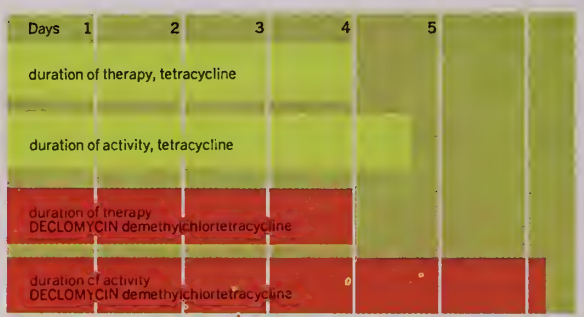
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Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measur should be taken. Use of demethylchlortetracycline duri tooth development (last trimester of pregnancy, neonat period and early childhood) may cause discoloration the teeth (yellow-grey-brownish). This effect occurs mos during long-term use but has also been observed in sh treatment courses. In infants, increased intracranial pre sure with bulging fontanels has been observed. All sig and symptoms have disappeared rapidly upon cessati of treatment. Side reactions include glossitis, stomatit proctitis, nausea, diarrhea, vaginitis and dermatitis. adverse reaction or idiosyncrasy occurs, discontinue me ication and institute appropriate therapy. Anaphylact reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i. Should be given 1 hour before or 2 hours after mea since absorption is impaired by the concomitant admi istration of high calcium content drugs, foods and sor dairy products.

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Precautions: Use with cautian in patients hypersensitive ta sympathomimetic compounds, wha have coronary or cardiavascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychalagical dependence.

Meprobamate: Careful supervision of dase and amounts prescribed is advised, especially for patients with known propensity far taking excessive quantities af drugs. Excessive and pralonged use in susceptible persons, e.g. alcoholics, farmer addicts, and ather severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dasage has continued far weeks or months, reduce dasage gradually. Sudden withdrawal may precipitate recurrence af preexisting symptoms such as anxiety, anarexia, ar insamnia; ar withdrawal reactians such as vomiting, ataxia, tremars, muscle twitching and, rarely, epileptiform seizures. Shauld meprabamate cause drawsiness ar visual disturbances, reduce dasage and avaid operation af matar vehicles, machinery ar ather activity requiring alertness. Effects af excessive alcahal cansumptian may be increased by meprobamate. Appropriate cautian is recommended with patients prone ta excessive drinking. In patients prone ta both petit and grand mal epilepsy meprabamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities ta patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insamnia, excitability, and increased mator activity are comman and ordinarily mild side effects. Canfusian, anxiety, aggressiveness, increased libido, and hallucinations have also been abserved, especially in mentally ill patients. Rebaund fatigue and depression may fallaw central stimulatian. Other effects may include dry mauth, anarexia, nausea, vamiting, diarrhea, and increased cardiavascular reactivity.

Meprobamate: Drawsiness may occur and can be assaciated with ataxia; the symptom can usually be contralled by decreasing the dose, ar by cancamitant administration af central stimulants. Allergic or idiasyncratic reactians: maculopapular rash, acute nonthrambocytapenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case af fatal bullaus dermatitis, fallowing administration af meprabamate and prednisalane, has been reparted. Hypersensitivity has praduced fever, fainting spells, angianeurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stamatitis, practitis (1 case), anaphylaxis, agranulocytosis and thrambacytapenic purpura, and a fatal instance af aplastic anemia, but anly when ather drugs known ta elicit these conditians were given cancamitantly. Fast EEG activity, usually after excessive dasage. Impairment af visual accommadatian. Massive averdasage may praduce drowsiness lethargy, stupar, ataxia, coma, shack, vasomotar and respirotory collapse.

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NEWS ITEMS

Woody G. Burrow, M.D. has opened an office for the practice of general medicine at 3021 Lone Oak Road, Paducah. Doctor Burrow graduated from the University of Tennessee School of Medicine at Memphis in 1961 and has served in the U.S. Navy since that time.

Charles L. Langsam, M.D., a psychiatrist, is now associated with the Henderson Clinic. Doctor Langsam graduated from Washington University in 1935 and has been a staff psychiatrist at the Southwestern Indiana Adult Psychiatric Center in Evansville.

Charles E. Peck, M.D., Russell Springs, was recently chosen Man of the Year by the Russell County Professional and Business Women's Club.

SPECIAL ARTICLE

(Continued from Page 591)

that every determination is somewhat inaccurate, this concept applies the calculus of probability to the results of a series of duplicate determinations to measure the degree of inaccuracy with great certainty. If we can be certain that our tests are inaccurate by only an insignificant error, we can use the results as confidently as if they were accurate.

While the philosophy and theoretical mathematics sound formidable, the American Society of Clinical Pathologists has made the application quite simple. Their 60-page *Quality Control Manual* converts the calculus to simple arithmetic which produces a presentation on graph paper that even he who runs may read at a glance. The specified standards are easily prepared, and the installation of quality control procedures in the clinical laboratory is hardly more difficult than a respectable high school science fair exhibit. The application can be as simple or as extensive as the surveyor wishes to make it. Simple standards can control almost any test, ranging from the routine office hemoglobin to the computations of the electronic cell-counter and hematocrit.

Ebstein's Anomaly

(Continued from Page 586)

tricuspid valve is formed from the lateral endocardial cushions at 11 mm. fetal length at a time when septation is also undertaking its shape. The septal leaflet of the valve is formed from the posterior endocardial cushion, the anterior leaflet from the fused anterior and posterior cushion. At this stage of development, the leaflets consist mainly of cushion material with very little muscular trabeculization.[11-13] It is probably at this time that the leaflets are displaced, resulting in the Ebstein's malformation of the heart.

It is obvious that incredible accuracy in timing is necessary to convert a simple heart tube into the complex-chambered system during the fifth to seventh weeks of fetal life, when both the cardiac septation and valve development are believed to occur.[9,10] The genetic imbalance inherent in D_1 trisomy may upset the normal mechanisms of embryonic cardiac development, as well as the development of other organ systems of the body.

The cardiac malformations that have been reported in the D_1 syndrome, including the present report of Ebstein's anomaly, do primarily involve abnormal events in septation and valve deformation. It has been postulated that the specificity of the complex of abnormalities found in the D_1 syndrome may be related to a general developmental error in the fetus during the fifth to seventh weeks of fetal age.[10] How the triplicated chromosome (with its extra genetic information) leads to such a unique derangement of cellular growth and metabolism at such a specific time of development is at present purely speculative.

Summary

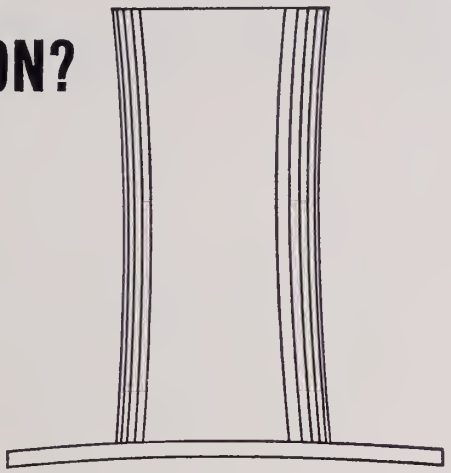
An infant with D_1 trisomy syndrome is described. Autopsy revealed Ebstein's anomaly of the heart, in addition to many of the other characteristic malformations of this syndrome. The possible embryogenesis of the cardiac defect, in relationship to the specific chromosomal anomaly, is discussed.

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Broader Benefits Increase Utilization of Health Plans

A STUDY recently released by the Blue Cross Association indicates, not surprisingly, that the better the benefits available under a health insurance policy, the higher the utilization is likely to be. The study is based on case histories of more than 1.8 million Blue Cross subscribers in Western Pennsylvania.

After analyzing the relationship between benefit levels and hospital utilization in almost every diagnostic category, the report suggests that the ability to select degree of coverage in anticipation of need—as in group conversion policies—is associated with higher utilization of benefits. It also finds that benefit restrictions such as waiting periods, deductibles, exclusions on pre-existing condition, and so on, definitely hold down utilization figures.

The first point was strikingly illustrated by the report's breakdown of hospital admissions according to whether patients had become insured as group members, had taken out policies as individuals, or had elected to convert from group to individual coverage after leaving employment. Group conversion members (broadest benefit choice), were highest in use, followed by group members, and individual contracts with restricted benefit choice.

Length of stay in the hospital is also shown by the report to be significantly influenced by benefit levels. The more comprehensive the benefits, the longer the policy holder tends to remain in the hospital. For example, persons insured under "master agreements", which generally provide for 120 days in-hospital care, have an average hospital stay of 8.8 days for all diagnoses, a full half-day longer than the 8.3 days for patients with "standard" 30 day coverage. In many diagnostic categories the difference in length of stay is two or three days.

The report does not condemn these longer stays as "excessive" utilization, but implies that, in some instances the patient's discharge from the hospital may be medically premature, because the subscriber with restricted benefits cannot or will not assume the full cost of further hospitalization. The investigators suggest that studies be made of the "post discharge" health care experiences of these enrollers in an attempt to further clarify this point.

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For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

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From the files of the
COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE 11-65. This patient was a 36 year old gravida 1 para 0 whose expected date of delivery was September 2. 1965. She was a nonclinic patient and had no prenatal care. She was first seen by the obstetrical department on September 17, 1965 when she was admitted to the delivery area in active labor. The patient stated she had been in labor for 12 hours prior to admission. There was no history of vaginal bleeding or loss of amniotic fluid. Initial examination showed the patient to be in active labor with a term-sized fetus. The fetal heart sounds were good; the blood pressure was 108/80 and the pulse 76. The patient had severe flexion contractures of both thighs with ankylosis of the hip joints. The patient had supposedly had "infantile paralysis" when she was three days old and was left paralyzed from the waist down. Pelvic examination showed the cervix to be 6 centimeters dilated. The amniotic sac was intact, the fetus was term-sized and the fetal heart sounds were of good quality. Consultation was obtained and cesarean section was advised because of the ankylosis of the hip joints. A low cervical cesarean section was performed with some difficulty under general anesthesia and a 5 pound 10 ounce infant with an Apgar score of 5 was delivered. The only complication was a laceration of the broad ligament which was repaired without difficulty. The patient tolerated the procedure well.

The first postoperative day was uneventful. On the second postoperative day the patient was noted to be somewhat distended but the bowel sounds were normal. She was placed on a liquid diet and intravenous fluids were continued. On the following day, the patient's abdomen was still distended but not as severely as before, and she stated that she was expelling flatus and the bowel sounds were good. The skin clips were removed on the third day, following which the patient had one temperature elevation to 102°. On the fourth postoperative day the patient seemed much improved. She continued to pass flatus and seemed less distended and much more comfortable. She was placed on a full liquid diet. On the following day she began to leak fluid from the upper end of the incision. At this time it was felt that the fluid could be urine and that she had developed a vesico-cutaneous fistula. A Foley catheter was placed in the bladder for continuous drainage. On the same evening she became more distended and it was felt that the distension represented a paralytic ileus. A Levin tube was placed in the stomach. Electrolytes drawn at this time were as follows: sodium 135 mEq, potassium 3.9 mEq, CO_2 23.1 mEq, chlorides 97.8 mEq. The patient was given fluids intravenously and on the sixth postoperative day seemed to be improving. The drainage through the incision had nearly stopped and the urinary output was good. Electrolytes were repeated and were found to be within normal limits.

On the sixth day the patient pulled out the Foley catheter and the nasogastric tube; both were promptly replaced. She seemed to be improving on the seventh postoperative day, and the abdomen was soft. The patient said she had passed flatus and had had a small bowel movement. The nasogastric tube was removed and the patient was placed on clear liquids and continued on intravenous fluids and on intravenous tetracycline because of a low grade fever of 100.4° for two days. Near midnight on the seventh postoperative day, the patient had a wound dehiscence. She was anesthetized with cyclopropane and succinyl choline. Intubation was extremely difficult and multiple attempts were made. Before the intratracheal tube could be placed, the patient vomited large amounts of coffee ground material, part of which she aspirated. Following this aspiration, five through-and-through stay sutures were placed in the abdominal wall, the eviscerated bowel was reduced, and the abdominal wall closed. The patient was given 500 cc whole blood and 800 cc Ringer's lactate during the procedure.

Immediately following the operation, the patient's respiratory efforts were considered insufficient and she was transferred to the recovery room where her respiration was assisted with a bag. The patient was ashen and cyanotic in spite of oxygen and assisted respirations. Auscultation of the chest revealed numerous rales and rhonchi in the lungs. The pulse was 132 and the pupils had become dilated and fixed. Shortly thereafter no heartbeat was heard and closed cardiac message was begun. Resuscitation efforts were continued until 5:45 A.M. without success, when the patient was pronounced dead. Permission for autopsy was refused. The cause of death was listed on the death certificate as aspiration following anesthesia.

This was classified as a direct obstetric death, with preventable factors. The Committee concurs that this was an anesthetic death; it would have been missed as a maternal death if only the cause on the certificate was known.

The Committee speculated in hindsight that since the baby weighed only 5 pounds 10 ounces, the patient might have profited from a longer trial of labor following artificial rupture of the membranes to see if she could have delivered vaginally with an episiotomy while lying on her side.



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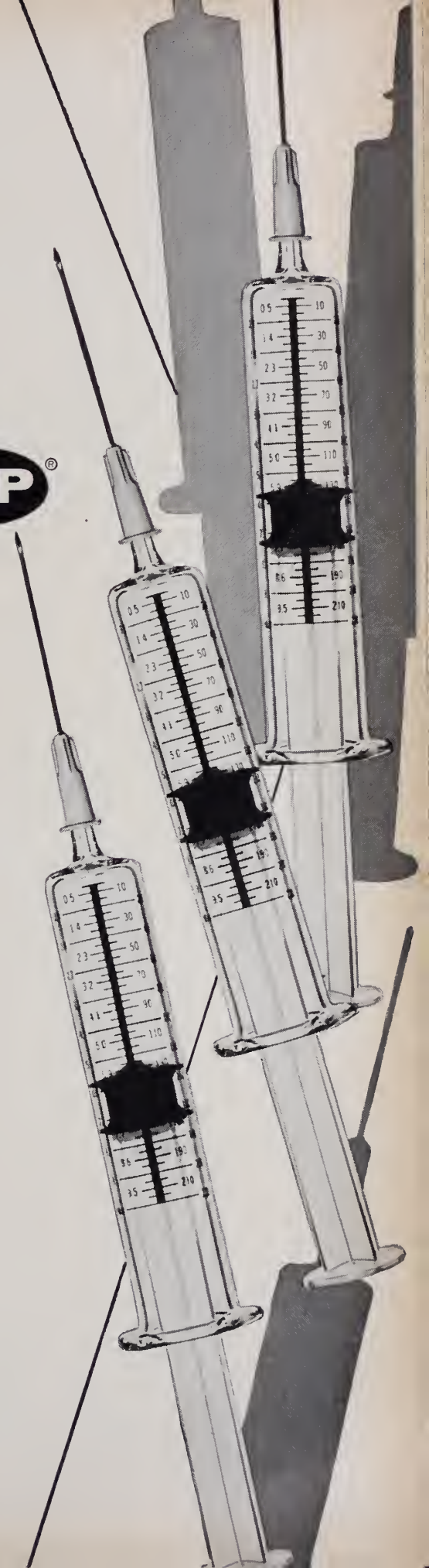
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JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

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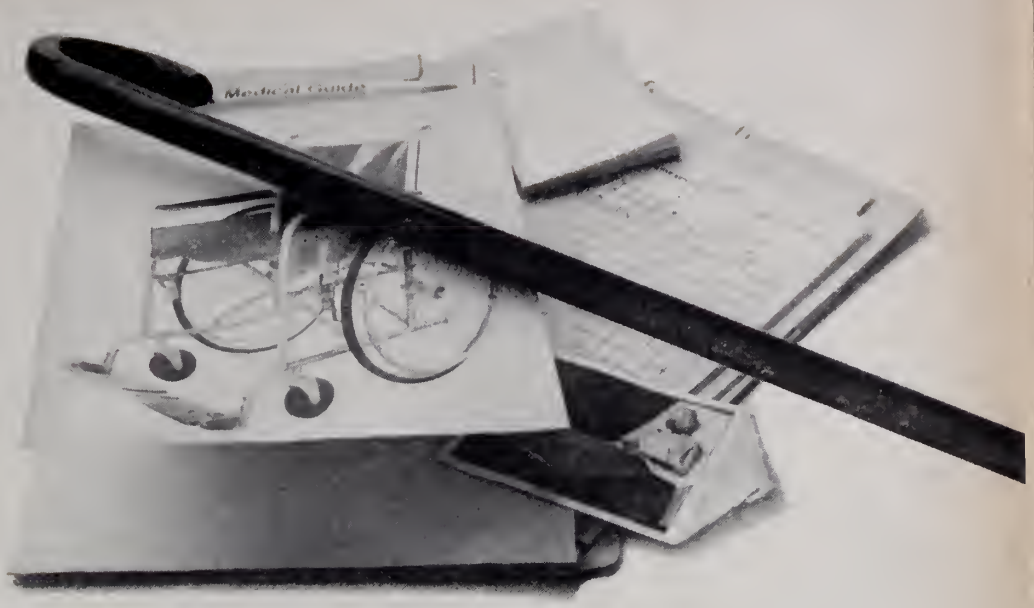
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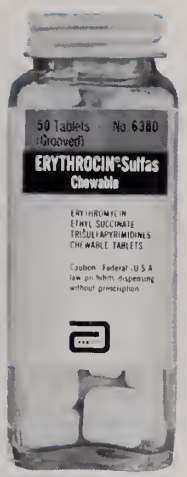
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In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

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87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

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53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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CURRENT CONCEPTS IN OPHTHALMOLOGY: by Bernard Becker, M.D. and Robert C. Drews, M.D.; Published by The C. V. Mosby Company, St. Louis, 1967; 265 Pages; Price, $17.25.

This book is a series of selected topics representing some of the current clinical work and interests of the staff of the department of ophthalmology, Washington University School of Medicine, St. Louis. The authors describe the format as one which is "less rigid and condensed than that required for journal publication" and "allows freer discussion for the authors".

Material relating to glaucoma comprises a major portion of the book (129 pp). Included therein is a well rounded course in the principles and application of tonography (89 pp) and a chapter which summarizes the authors' work on topical steroid response as it relates to the hereditary aspects of glaucoma.

Examples of other subjects reviewed are "diabetic retinopathy" and "sensory adaption in comitant strabismus." Another chapter "Ophthalmic Manifestations of Inherited Metabolic Diseases" provides a good synopsis with some handy reference tables as diagnostic aids. A few topics such as "blowout fracture of the orbital floor" and "rubella cataracts and rubella syndrome" will probably be repetitious for most ophthalmologists, because of their wide distribution in various journals. There is an enthusiastic report on the uses of fundus photocoagulation therapy.

Several chapters of an investigational nature may prove interesting. These include urokinase in traumatic hyphema, plantaris tendon in retinal detachment surgery, and "ophthalmodynamography". The latter is a method of evaluating carotid blood flow which has been used more elsewhere than in the United States.

In general the material is for the specialist (ophthalmologist or resident) and the presentation is in the style of the symposium or meeting with diverse current papers on the agenda.

WILLIAM C. EDWARDS, M.D.

DIABETES FOR DIABETICS: by George F. Schmitt, M.D.; Published by Diabetes Press of America, Miami, 1965; 237 Pages; Price, $5.95.

This book, whose title defines its purpose, can be warmly recommended to the literate diabetic patient. Moreover, physicians who essay to treat this mysterious mellitic malady may learn a thing or two from its pages.

In patient, simple terms the author outlines the fundamental problems posed by diabetes and indicates the objectives of treatment. Properly, diet is next considered. Essentials of digestion and nutrition are described, again in familiar words. The supreme importance of dietary control is emphasized. A fairly full list of foods with their "exchange" values is included and will serve patients as a helpful reference.

Next, insulin is considered, In addition to a lucid description of the various insulins, the many little details of its use—old hat to the doctor but confusing to the patient—are explained clearly. Oral hypoglycemic agents, general body care, complications of diabetes, and the distinctive features of juvenile diabetes are discussed adequately and simply.

A pleasing innovation in this book is the "Test Yourself" quiz at the end of each chapter. The patient who is able to answer all the questions correctly will, indeed, have a good knowledge of his disorder.

The predatory reviewer will find himself frustrated at first contact with this presentation. For on the jacket he is told that no one concerned with the publication of "Diabetes For Diabetics" receives any financial compensation. Instead, the profits resulting from its sale will be placed in a fund to send underprivileged diabetic children to summer camps. How can one fault the fruits of such a project? Yet the notion persists that the price of this tome to the reader might have been less were it not for the lavish use of excellent color photographs. Granted that a picture is worth at least a thousand words, the elegant camera studies of a frankfurter, an egg, a brace of broccoli seem hardly worthwhile. Other photographs, however, definitely are.

JAMES ROBERT HENDON, M.D.

The Mediatric® Age:

Many patients, with or without a functional illness, show symptoms o
an aging metabolism: disinterest... lassitude... vague aches and pains.

Mediatric® can help them lead a more active, useful life



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"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging.... This therapy resulted in improvement of 75 per cent of the patients...."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

The estrogen content is PREMARIN® (conjugated estrogens—equine), the orally active, natural estrogen most widely prescribed for its superior physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain an anabolic balance to forestall premature deteriorative changes of aging.

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CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: **Male and female:** 1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	–
Thiamine HCl	–	5.0 mg.
Thiamine mononitrate	10.0 mg.	–
Riboflavin	5.0 mg.	–
Niacinamide	50.0 mg.	–
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726



Insurance Alters Medical Practice

FEW COULD argue with the fact that our modern system of voluntary health insurance has been partly responsible for the vast increase in quantity and quality of overall health care in this country in the past three decades. The medical profession and many other health care authorities are, however, becoming rightly concerned about certain areas of medical practice in which benefit curbs and restrictions are distorting effective and economical delivery of quality care, and in certain instances, even encouraging poor quality care.

Benefit schedules have often been designed to fit into an existing administrative and financial framework. If modern patterns of care are to achieve their potential, finance and administration must be revamped to fit the needs of medical services.

Hospitalization benefits are considered to be the basic component of many plans, not because it is the most important item of health care, but because it affords a way to police other benefits. Many diagnostic and therapeutic procedures are not covered unless the insured is hospitalized. As a result, needless and wasteful resort to hospital admission is encouraged as patients seek to acquire and physicians to provide care which would not otherwise be available.

Surgery is over emphasized, not because it is more insurance-worthy but because it is more easily verified and causes fewer administrative headaches.

As a result, care for an ingrown toenail is a commonly insured procedure while cancer and heart disease are often ignored until the condition becomes severe enough to require hospital admission. Other specialities and important segments of health care (psychiatry, preventive procedures, rehabilitation, etc.) are often omitted or grossly under insured.

Private health insurance in this country is clearly a vigorous, competitive and healthy institution. But as it grows and matures, its problems multiply and become more complex. The vast increases in total enrollment and breadth of coverage in recent years have been gratifying; however lack of depth and balance of benefits pose a continuing challenge to the industry. In the past, considerable resourcefulness has been demonstrated by private health insurance in solving problems. The solutions to problems such as these are significant to the future of health care in this country.

WILLIAM W. HALL, M.D.



"When I couldn't even smell corned beef and cabbage, I decided it was time for you, Doc."

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1— a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

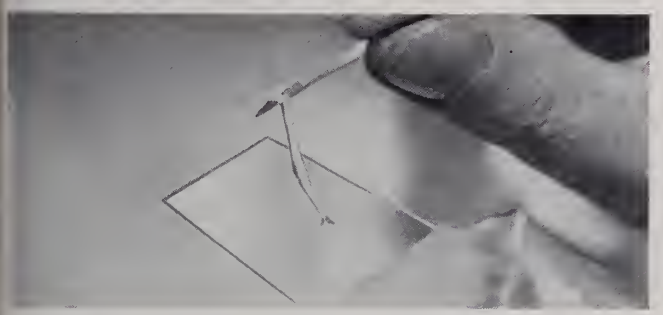
But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

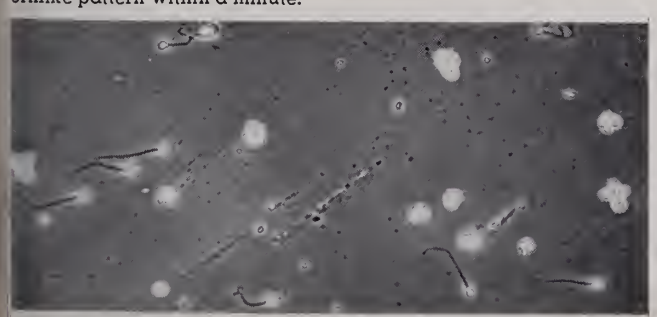
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

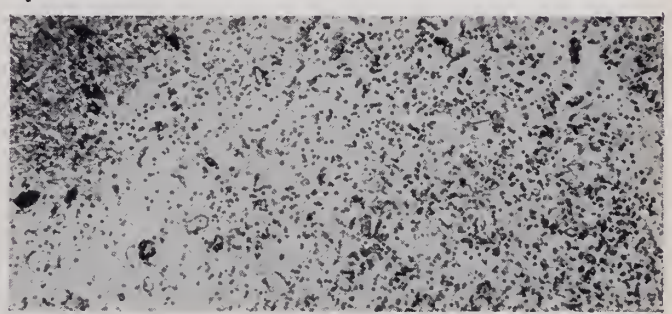


Spermatozoa appear healthy, are active and freemoving.

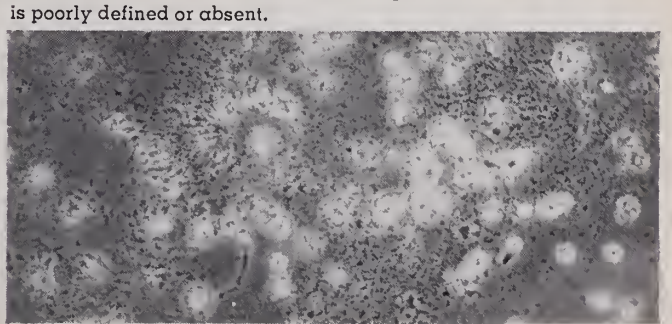
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

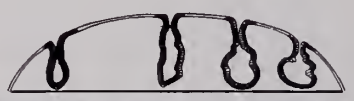


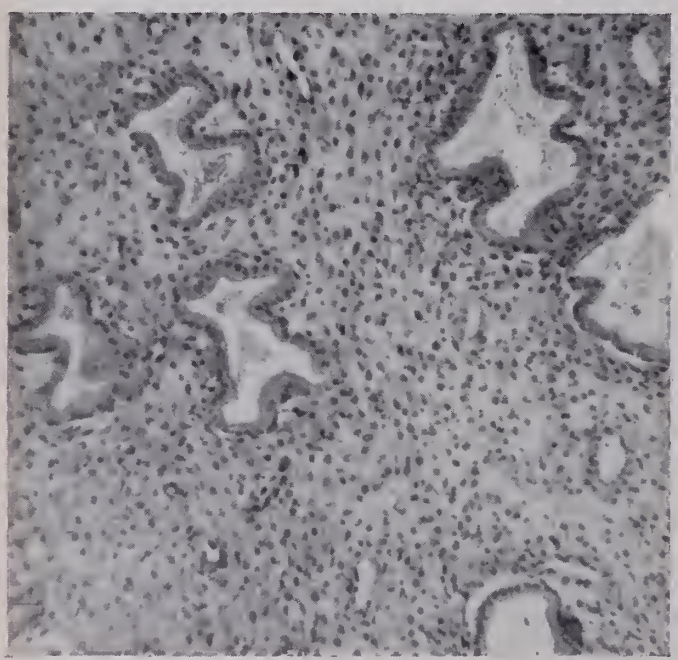
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses– another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

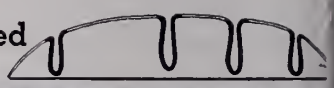
Endometrium of untreated patient

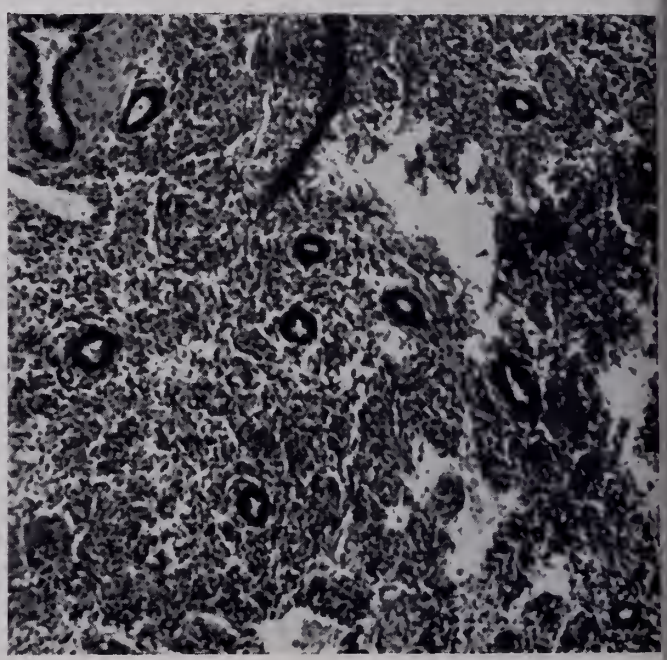




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl-1® (norethindrone 1mg. & mestranol 0.05mg.) tablets

See last page for contraindications, precautions, side effects and dosage.

ffective fertility control
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orethindrone/mestranol
ombination

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Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

ESCRIBING INFORMATION

ntraindications: I. Patients with thrombo-
lebitis or with a history of thrombophlebitis
pulmonary embolism. 2. Liver dysfunction or
ease. 3. Patients with known or suspected
cinoma of the breast or genital organs. 4. Un-
gnosed vaginal bleeding.

rnings: I. Discontinue medication pending
mination if there is sudden partial or com-
te loss of vision or if there is a sudden onset
proptosis, diplopia, or migraine. If examina-
n reveals papilledema or retinal vascular
ions, medication should be withdrawn. 2.
ce the safety of Norinyl-1 in pregnancy has
been demonstrated, it is recommended that
any patient who has missed two consecutive
iods, pregnancy should be ruled out before
tinuing the contraceptive regimen. If the pa-
t has not adhered to the prescribed schedule,
possibility of pregnancy should be consid-
d at the time of the first missed period. 3.
tectable amounts of the active ingredients in
l contraceptives have been identified in the
k of mothers receiving these drugs. The
nificance of this dose to the infant has not
en determined.

cautions: 1. The pretreatment physical exam-
tion should include special reference to
east and pelvic organs, as well as a Papani-
aou smear. 2. Endocrine and possibly liver
nction tests may be affected by treatment
th Norinyl-1. Therefore, if such tests are ab-
rmal in a patient taking Norinyl-1, it is recom-
nded that they be repeated after the drug
s been withdrawn for 2 months. 3. Under the
luence of estrogen-progestogen preparations,
existing uterine fibroids may increase in
e. 4. Because these agents may cause some
gree of fluid retention, conditions that may
influenced by this factor, such as epilepsy,
graine, asthma, cardiac, or renal dysfunc-
n, require careful observation. 5. Although a
use and effect relationship has not been
ablished, Norinyl-1 should be used with cau-
n in patients with a history of cerebrovascu-
accident. 6. In relation to breakthrough
eeding, as in all cases of irregular bleeding
r vaginam, nonfunctional causes should be
rne in mind. In cases of undiagnosed vaginal
eeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

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PUBLIC HEALTH PAGE

Bridging The Gap In The Continuity Of Patient Care-Home Health Services†

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

A BROAD new program of health care has been made available to all Americans 65 or over through the enactment of Title XVIII of the Social Security Amendments of 1965 and for selected beneficiaries, regardless of age, included in Title XIX, administered by the Kentucky Department of Health. One of the provisions of this health care includes *Home Health Services.* An integral part of progressive patient care, accessible to physicians, is currently being developed in Kentucky through the establishment of home health agencies.

The development, expansion and certification of home health agencies by the Kentucky Department of Health will play a prominent part in the continuity of care. Certified home health agencies must include a minimum of at least skilled nursing services and one other therapeutic service (physical therapy, speech therapy, social services, etc.), on a visiting basis in a place of residence used as the patient's home.

Physicians referring patients to the agency are required to establish a written plan of treatment. A plan is "established" when it is reduced to writing by the referring physician and is made available to the home health agency which has accepted the patient as a client. The plan must specify the types of services required and should, as far as possible, provide a long-range forcast of likely changes in the patient's condition. It should include diagnosis, when and what nursing services are needed, drugs and medications to be used, diet, activity permitted, rehabilitation, therapy needed, home health aide services needed, and supplies and appliances needed. The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires but at least every two months.

Agencies rendering services to homebound patients may be based in (1) a county or city health department (2) a general or community hospital (3) a Visiting Nurse Association or (4) an independent agency, established for this purpose. As of June 1, 1967, four (4) hospital based agencies, seven (7) county health department home health agencies and two (2) Visiting Nurse Associations have been certified to participate in this program in Kentucky. Five (5) other county health departments and hospitals are establishing home health agencies and are expected to be certified by the fall of 1967.

Home health services under Medicare require the cooperation of all the medical disciplines within the community. It is primarily the private physician's program as there can be no home care for the patient unless the physician refers and submits a plan of treatment for his patient. This program will bring a more adequate level of medical and nursing supervision to many home-bound patients and enable them to receive quality care in their home, thus decreasing the need for hospitalization. It will also enable the private physician to discharge some of his patients from the hospital at an earlier date, knowing that the continuing care program in the home will provide adequate nursing and therapeutic service.

With the cooperation of all the segments of the community involved in the program, the physicians should feel satisfaction in that their home-bound patients are better cared for, the patients should have an improved state of health, and the home health agencies and the community should feel a sense of accomplishment in this area of patient care.

† *This material was prepared by Sherrill Ritter, Jr., Director, Home Health Services, Office of Local Health*

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OCTOBER

2-6 American College of Surgeons, Conrad Hilton, Chicago

11-12 Indiana State Medical Association, Murat Temple, Indianapolis

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29 American Association of Ophthalmology, Palmer House, Chicago

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Educational Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

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VOLUME 65 July 1967 No. 7

Surgery for Iliofemoral Venous Thrombosis †

GILES L. STEPHENS, M.D.*

Louisville, Kentucky

Thrombectomy for acute Iliofemoral Venous Thrombosis is advocated. The diagnostic criteria, description of operation, operative, and early postoperative results are presented.

THE primary objective of thrombectomy is the preservation of the venous valves in order to prevent ambulatory venous hypertension with its known sequelae of the post-thrombophlebitic syndrome. Following the publication of Alex Haller's paper in 1961, the author became interested in thrombectomy for acute iliofemoral venous thrombosis.[6] This operation was proposed by Leriche in 1928[4]; however, it fell into disuse because of the high incidence of failure and was subsequently reintroduced by Howard Mahorner in 1957.[9] At St. Joseph Infirmary, Louisville, since 1961, 16 patients with iliofemoral venous thrombosis have had thrombectomy performed.

Diagnosis

Diagnosis can be made clinically only when there is edema of the entire leg from toe to groin with tenderness over the femoral vein in the femoral canal. The involved lower extremity usually is warmer than the normal, but this will depend upon the degree of sympathetic nervous activity, and the skin of the leg may even be cooler than the normal one. There are usually dilated superficial veins but these are not invariably present. The most reliable sign of iliofemoral venous thrombosis is uniform swelling of the extremity associated with tenderness over the femoral vein in the femoral canal. Venography is not required in making this diagonsis. Those patients with thrombosis who have incurable visceral cancer are not subjected to thrombectomy but are treated with anticoagulants and bed rest with elevation of the foot of the bed.

Description of Operation

After the diagnosis is made, blood is typed and crossmatched and 1500 cc of blood should be immediately available. Moderate preoperative medication is administered. A Lee White coagulation time, c.b.c., urinalysis and chest x-ray are obtained pre-operatively. The entire affected lower extremity is shaved and the entire abdomen is shaved, then this area is carefully prepared, in the operating room, with a colored Zephiran® solution. Vigorous mechanical cleansing of the thigh is purposely avoided for fear of dislodging part of the venous thrombus. After sterile draping, 1½% Xylocaine® local anesthesia is used. A longitudional incision is made over the femoral vein beginning at the level of the inguinal ligament and extending the incision about 5 inches inferiorly. The incision is extended cephalad, following the inguinal crease for about 2 inches. The femoral artery and vein are dissected free by sharp and blunt dissection and prophylactically papavarine is injected into the

†*Presented April 28, 1967, at the meeting of the American College of Surgeons, Kentucky Chapter, Louisville*

**Director of Surgical Training, St. Joseph Infirmary*

adventitial tissue of the femoral artery to prevent arterial spasm. Umbilical tapes are passed around the common femoral, superficial and deep femoral veins and the superficial femoral artery. The diagnosis is confirmed with the finding of a thick, edematous, bulging femoral vein. After umbilical tape control of all the smaller venous tributaries in the area has been obtained, an incision is made longitudionally in the common femoral vein and at this point the patient is given 50 mgm. of heparin i.v. As soon as the venotomy has been done the patient is asked to tense the abdominal muscles and if the proximal venous thrombus does not escape from the iliofemoral vein at this time then manual compression with the hand on the abdomen is of great assistance. If backbleeding is not brisk, a rubber or plastic catheter can be very cautiously advanced cephalad. The catheter must *not* be advanced unless it is on suction to prevent dislodgment of a proximal thrombus and subsequent pulmonary embolization. The catheter should be advanced until excellent backbleeding is obtained or until it reaches the level of the inferior vena cava. After vigorous backbleeding has been obtained, umbilical tape constriction of the proximal venous segment is obtained and 5-10 cc of a heparin solution (10 mg. dissolved in 100 cc of saline) is injected into the common femoral vein after which by vigorous manual milking action, starting in the distal calf region and proceeding proximally, the distal venous segment is cleared. In the author's experience milking of the calf is much more effective than compression with an elastic bandage. If bleeding is not obtained distally the catheter may be introduced distally under suction to remove the remaining clot. A gallstone forceps may judiciously be employed in manually extracting clot both proximally and distally. After vigorous bi-directional bleeding has been obtained, the venotomy wound is irrigated with the heparin solution and the venotomy wound is closed with a continous 5-0 arterial silk suture using the technique of Carell. The wound is irrigated with copious amounts of saline after which a large Penrose drain is brought out a stab wound near the inferior end of the thigh incision and the wound is closed in layers with interrupted chromic catgut with interrupted 4-0 cotton sutures in the skin. Sterile dressing is applied to the wound and the extremity is wrapped from the base of the toes to the groin with elastic bandages. The patient is kept in bed with the foot of the bed on 4 inch shock blocks for 5-7 days. The patient is given i.v. heparin for the first three days postoperatively, keeping the Lee White time at approximately 1½ times normal. The patient is given prophylactic choloromycetin because of the less than ideal skin preparation pre-operatively. After 72 hours the patient is started on Coumadin® therapy after obtaining a control prothrombin activity. Coumadin anti-coagulant therapy is continued for 21 days. An elastic bandage to the level of the tibial tubercle is worn for two months postoperatively.

Results

Since 1961, 16 patients at the St. Joseph Infirmary have had thrombectomy for iliofemoral venous thrombosis. All were Caucasian; there were 3 males and 13 females. The age range was from 19 to 86 years, and the mean age was 44 years. The right lower extremity was involved in 3 cases and the left lower extremity in 13 cases. The average time from onset of iliofemoral venous thrombosis to thrombectomy averaged 36 hours.

Some of the cases had more than one etiological factor. Eight patients were either recent or fairly recent postoperative cases, two were post-partum, and two were antepartum. Prolonged bed rest was an etiological factor in four cases. Cancer was present in three patients, and four patients had a past history of entire lower extremity venous thrombosis. Three of the patients were taking oral contraceptive tablets.

Operation results	Percentage
Excellent	9 cases - 56%
Good	3 cases - 19%
Fair	2 cases - 12.5%
Poor	2 cases - 12.5%
Mortality	0%

The average blood replacement in the operating room was 594 ml. and the average postoperative blood replacement was 531 ml. The average total blood replacement was 1125 ml.

Wound hematoma was detected in five cases and in three of these there was a wound infection.

Two patients had plumonary emboli in the postoperative period. Both of these embolic

episodes occurred on the first postoperative day. One of these patients was ambulated on the first post-operative day. The other patient had incomplete thrombectomy; there being very poor backbleeding from the proximal iliofemoral venous segment and subsequently retroperitoneal lymphnode metatases in the region of the vena cava were demonstrated.

In the majority of cases the clinical record revealed minimal or slight residual edema at the time of discharge and dramatic reduction in the amount of pain and soft tissue swelling within the first 24-48 hours following a successful thrombectomy.

The average number of days that the patient was kept at bed rest with elevation of the foot of the bed was 5.2.

The postoperative hospital stay averaged 17.8 days. This average figure would have been less had one case been excluded. This patient's thrombectomy was a failure and he subsequently developed vena caval thrombosis requiring 80 days of hospitalization. Retroperitoneal lymphnode metastases were subsequently found.

No definite or fixed rule of postoperative anticoagulant therapy was followed in this series. The majority of the patients were given 50-100 mgm. of heparin i.v. at the time of exposure of the thrombosed femoral vein, prior to extraction of the thrombus. The patients in general were given intermittent i.v. heparin for 72 hours and then subsequently changed to intermittent Coumadin therapy which was continued for from 2-4 weeks after the thrombectomy.

Venography has not been performed on a sufficient number of these patients in the postoperative period to be of any statistical significance.

Discussion

The primary objective of thrombectomy for iliofemoral venous thrombosis is, as stated previously by Mahorner[9] and Haller[7], the preservation of the integrity of the venous valves to prevent ambulatory hypertension with its known sequelae of the post-thrombophlebitic syndrome. This operation is not performed primarily to prevent embolization.

Vena caval ligation has its definite place for this condition. Possibly vena caval compartmentation or fenestration will subsequently prove to be superior to vena caval ligation but I doubt it.

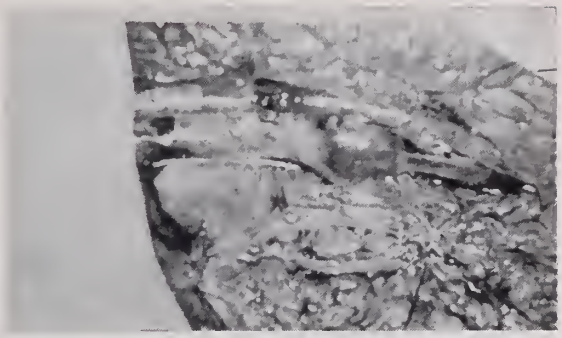


FIGURE 1. Thrombosed edematous femoral vein adjacent to femoral artery.

It is evident from the published studies of Haller that the degree of technical completeness of thrombectomy is directly related to the time interval between thrombosis and thrombectomy. In his series there was a striking difference between the results obtained in patients operated on within 10 days post-thrombosis compared to those who had thrombectomy performed from 14-21 days after the onset of venous thrombosis. In Haller's series the results of thrombectomy were 26 normal limbs in patients who had been operated on during the first 10 days compared to one normal limb in a patient who had been operated on from 14-21 days post-thrombosis. Of 18 patients having postoperative venograms who had early thrombectomy (the first 10 days post-thrombosis), 15 were normal. Among 4 patients having late thrombectomy (14-21 days post-thrombosis) all 4 showed a major venous occlusion on the venogram. It is also noteworthy that 2 of 11 patients in Haller's series who had a normal appearing limb post-thrombectomy had a major venous occlusion on subsequent venography[7]. Hence, a normal appearing limb does not absolutely exclude the presence of a major venous blockade and it does not negate the possibility of the patient subsequently developing ambulatory venous hypertension after recanalization of the deep veins. I am familiar with a patient not reported in this series who had surgery on November 11, 1962; he died from an acute myocardial infarction one month post-thrombectomy and had at the time of death a normal appearing lower extremity, though the autopsy showed complete occlusion with fibrous organization of the iliofemoral vein.

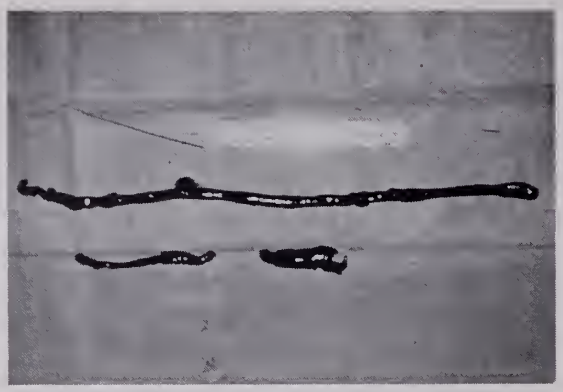


FIGURE 2. Iliofemoral venous thrombi. The longest segment was 15 inches.

The advent of the Fogarty venous thrombectomy catheter has created enthusiasm for late iliofemoral venous thrombectomy and it is being used by Mahorner, DeBakey, Fogarty, and others[2,3,5]. I would recommend thrombectomy during the first five days post-thrombosis fully realizing that the sooner the thrombus is extracted the less intimal damage will acrue and less proximal and distal venous thrombus propagation will be present. I seriously question the safety of late thrombectomy, especially since with this technique there is no proximal venous control to prevent any dislodged venous thrombi from going to the lungs. Although the reported incidence of pulmonary embolization following iliofemoral venous thrombectomy in only 3.2%[10]. I believe that the incidence of pulmonary embolization in late thrombectomy cases is probably much higher than is reported in the current surgical literature. None of these cases of pulmonary embolization resulted in a fatality. The reported incidence of pulmonary embolization secondary to iliofemoral venous thrombosis has varied from 12 to 40% with 5-25% resulting in death[10]. Vigorous pre-operative scrubbing of the femoral vein region is hazardous and I am familiar with one patient at another hospital who had a massive pulmonary embolus on the operating table while the lower extremity was being scrubbed. For this reason very gentle preparation of the skin has to be carried out prior to thrombectomy. The pre-operative medication should not obtund the patient so that the patient may vigorously cooperate in performing the Valsalva maneuveur to assist in extrusion of the venous thrombus after the venotomy and this is why local anesthesia is the anesthestic of choice.

G. W. Smith states that the distal progress of the Fogarty venous thrombectomy catheter is often impeded by the venous valves[10]. Bradham and Buxton[1] have stressed the point that it is important to realize that there is a significant loss of blood during thrombectomy at the time the suction catheter is inserted into the proximal iliac vein. One of our patients went into shock secondary to the rapid blood loss while the catheter was maintained on suction.

I recommend that three pints of cross matched blood be available pre-operatively and that a 13 gauge needle be inserted in a vein in each upper extremity before thrombectomy. Although a local anesthetic is employed by the surgeon an anesthesiologist should be at the head of the operating table to promptly correct any blood loss that may occur.

As of December, 1965, only 158 cases of iliofemoral venous thrombectomy have been reported in the surgical literature[10]. Of the 100 cases in which the proficiency of the operative results was stated, 85% were recorded as good and 15% were recorded as poor. The clinical results in the series of 158 patients have been recorded as excellent in 41%, satisfactory in 43%, with 7% failure. A 4.5% mortality related to the iliofemoral venous thrombosis and 4.5% mortality unrelated to the iliofemoral venous thrombosis or the operative procedure were reported. Aside from the series of Rene Fountain[4] none of these patients has at this time been followed longer than two years post-thrombectomy.

I feel that these patients should be maintained at bed rest with the foot of the bed elevated on 4 inch shock blocks for a week before ambulation and that vigorous dorsi-flexion of the feet should be carried out 10 times every waking hour. The head of the bed should not be elevated because angulation of the iliofemoral vein increases the incidence of venous stasis and possibly subsequent re-thrombosis.

I agree with Linton[8] that if the thrombus is localized to the iliac and proximal femoral vein, there is a theoretical consideration for earlier ambulation. However, in our series some of the patients have had distal propagation of the thrombus into the deep calf veins and it is my impression that probably not all of the distal thrombus is completely removed. Therefore the danger of venous embolization is greater in these patients; hence, they should

be kept at absolute bed rest for a week while on anti-coagulant therapy.

I would stress the importance of meticulous use of the Carell technique for suture of the venotomy wound and that the large Penrose drain be brought out through a separate stab wound prior to closure of the wound in layers. Theoretically, the Penrose drain should not lie in direct contact with the femoral vein because of the possibility of altering the electrical charge and causing re-thrombosis.

Summary

At the St. Joseph Infirmary 16 patients with acute iliofemoral venous thrombosis have had venous thrombectomy. The mean time from onset of thrombosis to thrombectomy has been 36 hours. In 75% of these patients a technically excellent or good operative result was obtained; 12.5% were rated as fair and 12.5% were judged as poor. There was no mortality. The mean blood replacement during thrombectomy was 595 ml. and the mean blood replacement post-operatively was 531 ml. The total mean blood replacement was 1125 ml.

Considerable blood can be lost while the proximal venous segment is being cleared with the suction catheter. Adequate blood should be available at the time of thrombectomy. Two patients had a pulmonary embolus on the first postoperative day.

Immediate thrombectomy is advocated as the treatment of choice for early acute iliofemoral venous thrombosis, to preserve the integrity of the deep venous valves in order to prevent ambulatory venous hypertension with its known sequelae of the post-thrombophlebitic syndrome. This operation offers prompt relief of pain and massive swelling of the lower extremity and markedly diminishes the threat of pulmonary embolization if proper anticoagulant therapy is maintained postoperatively. Critical selection of patients among those who present within 5 days of onset of thrombosis is recommended. Late venous thrombectomy probably does more harm than good. A statistically significant number of patients with iliofemoral venous thrombosis, treated by thrombectomy and followed for a period of at least five years, will be necessary for final evaluation of the operation.

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Allergic Reactions to Insect Stings

LLOYD D. MAYER, M.D.*
Lexington, Kentucky

A statistical review and discussion of the immunology, symptomatology and treatment of allergic reactions to insect stings. Methods of preventing these reactions and the use of hyposensitization are described in detail.



FIGURE 1. a—HONEY BEE (Apis meliferal; b—WASP (Polistes spp.); c—HORNET (Dolichovespula spp.); d—YELLOW JACKET (Vespula spp.); e—BUMBLE BEE (Bombus

ALLERGIC reactions to insect stings are most frequently caused by the order Hymenoptera which includes bees, wasps, hornets, yellow jackets, and fire ants. (Fig. 1)

During the ten year period ending in 1959, it was noted that venomous snakes killed 138 persons while Hymenopterous insects killed 229. Death was attributed to bees in 124 persons, to wasps in 69, to yellow jackets in 22, to hornets in 10, and to fire ants in 4. The interval of time between the sting and death, recorded in 208 of the 229 fatalities, was less than an hour in 80% of the victims. The suddenness of death has focused attention on emergency measures and desensitization procedures.[1,2,3]

In a survey of 2,606 patients studied under the auspices of the Insect Allergy Committee of the American Academy of Allergy it was found that many patients had generalized reactions to insect stings without a history of previous unusual or even local reactions to the sting. In this group the greatest number of severe reactions to stings occurred in August.

Approximately one-third of the persons having allergic reactions to insect stings have a personal history of allergy. Even in these patients, as well as the non-atopic individuals, severe generalized reactions in over half of the registrants studied were unheralded by any warning. It was also noted that in 65% of the cases a person once sensitized had increasingly severe reactions to subsequent stings.[4]

However, one cannot predict the severity of an individual reaction based on a previous history. Different reactions may be produced by different insects in the same person (i.e., a bee may produce local swelling and a wasp generalized reaction with unconsciousness).[4]

A sharp rise in incidence of reaction was noted in both sexes after the age of 30 years.[4] Severe systemic reactions may occur at any age, however, and the youngest child known to have had a fatal reaction was four years old.[5] Those patients who have heart disease are outstandingly susceptible to a fatal outcome following insect stings.[2,6,7] Hence it has been recommended that persons who are 40 years or older, and who work outdoors, should have an emergency kit available because of the unpredictability and increasing severity of the reactions in this age group.[2,3,7,8,9]

Symptoms

The manifestations of allergy vary greatly. In one person there may be little or no local reaction with severe generalized symptoms.

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The individual may react to one type of insect and not to the other, as mentioned above, or react in a terrifying manner only after a number of bites.

The immediate local type of reaction is a severe swelling at the site of the sting which may last for hours or as long as one week. The delayed type of reaction consists of prominent swelling at the site of the sting 24 hours or more following the stinging episode which may continue for several days to a week and may include arthralgia and urticaria. The immediate type of systemic reaction consists of acute anaphylactic shock, generalized urticaria, allergic edema of the larynx, trachea, and bronchial tree with bronchospasm. The syndrome may also include hypotension, tachycardia, sweating, and other manifestations of shock. Some dizziness, nausea, and/or vomiting may also occur in the generalized or systemic reactions. A reaction in the form of headache alone is not usually considered a symptom, especially if the patient was stung on the head or face. Some patients may have both immediate and delayed reactions to the same sting.

Sensitization

The usual method of sensitization is by the stinging welt and, as has been pointed out before, 65% of the patients who continue to have reactions develop severe reactions unless they have been hyposensitized.

In order to explain the reactions that occur in people who may never have been stung before, or in those who have had no local reactions to stings, one might propose that the inhalant route might be the method of primary sensitization. Many of the insects mentioned die and break down to form dust which can be inhaled and sensitize the patient. There is a crossed reactivity between bees, wasps, yellow jackets, and hornets, not only in the venom sacs of the bees but also in the whole body antigens as well. This offers a possible explanation for the severe sensitivity that occurs in patients without any previous history of sting reaction.[6,10,11,12] In addition, patients may have been stung by a bee without trouble and have a severe reaction to a wasp. This is caused by the crossed antigenic relationship of these insects. It is therefore felt now that the sting of any one of the Hymenoptera may induce sensitivity to any one of the four groups. This is particularly true between the whole body antigens of the bee and wasp, and between the bee and yellow jacket. The reverse also occurs in that sting of wasps and yellow jackets may induce sensitivity to bee stings.[10]

Treatment

For the treatment of the generalized type of reaction, epinephrine 1-1000 remains the drug of choice in the management of these cases. The epinephrine is used following the removal of the stinger which is done with the fingernail in a flicking motion or by the use of tweezers. Squeezing between the forefinger and thumb only tends to squeeze more venom into the site. A tourniquet should be placed above the site for a short period. The epinephrine is given in a dosage of 0.20 c.c. to 0.50 c.c., or less depending upon the age and weight, intramuscularly proximal to the tourniquet. The epinephrine may also be injected in the opposite arm if desired. In addition, infiltration with 0.10 c.c. into the sting site will help to slow down the absorption of the venom and insect antigen, as well as neutralize some of the histaminic effects if a bee has stung the individual. As is known, the bees leave the stingers with the venom sac attached into the skin, whereas the wasps, yellow jackets, and hornets do not. Epinephrine may be given intravenously if the patient is in shock and, in addition, intravenous fluids containing vasopressors may be necessary. During this infusion, injectable antihistamines may be given, or they may be given intramuscularly following the adrenalin. Oxygen and tracheotomy may be necessary, and hospitalization for the treatment of cardiovascular and respiratory collapse may be also required. The patient should be placed on automatic ventilation if there is respiratory failure, as well as keeping a cardiac resuscitator nearby. Corticosteroids are the last drugs to be used and are used for the prevention and treatment of delayed reactions following the severe, immediate, collapse-type reaction. The inhalation of isoproterenol may also be life saving in some of these patients who have severe wheezing and dyspnea as well as some laryngeal edema. The sublingual use of isoproterenol and ephedrine in the form of Nephenalin® or Isufranol® or plain Isuprel® is beneficial. If the patient is not too uncomfortable and can swallow oral preparations, the use of antihistamines and ephedrine in addition to isoproterenol is help-

ful. If wheezing is very severe and the patient is not in shock, aminophyllin may be administered either intravenously or per rectum if epinephrine is not available or helpful.

For the treatment of the local reactions, the use of ice packs at the site, antihistamines and ephedrine systemically, as well as corticosteroids orally and locally in the form of creams or ointment may be beneficial. The local type reaction presents little hazard, but is uncomfortable to the patient. However, it may be of some importance should the sting occur in a vital area such as near the throat or urethra. In these cases, appropriate by-pass procedures may be necessary as well as the emergency measures described previously.

Differential Diagnosis

Many patients are stung without knowing exactly what type of insect has stung them. Bee venom has immediate histaminic effects as noted by the local swelling and wheal formation with erythema. It also has certain hemolytic and neurotoxic effects and prolongs the coagulation time. Severe pain along the nerves from the site of the sting is a frequent complaint. These reactions are of the non-allergic variety but resemble a toxic type of reaction.[2,13] However, these toxins may act as antigens and produce hypersensitivity eventually.

The sting of mosquitoes and fleas in certain people does produce an allergic response, but severe reactions are infrequent. Flea bites may produce papular urticaria in young children which appears to be associated with a delayed type of immunologic response.[2] The papular urticaria victim has intense itching so that many times one sees only the severe crusting and infection of the lesion without the true papule. One does obtain a history of contact with an animal who has fleas. Treatment with 5% to 10% DDT, used as an aerosol bomb or powder, is very helpful along with calamine lotion, antibiotic-corticosteroid creams and oral antihistamines. One must not dismiss the possibility that in some children the lesions may be due to ingestion of milk, eggs, wheat, and other foods, and may be a true urticaria. Usually, one can see the small bite at the center of the lesion which is rather round and regular, whereas, the urticarial lesions are unevenly shaped. While lesions due to bites remain in one place, urticarial lesions due to systemic allergy come and go in different parts of the body.

Between 1950 and 1959 the Hymenopterous insects killed 229 people, the Arachnids (spiders and scorpions) killed 73. The black widow spider is the chief offender and has on its ventral surface the hourglass design colored red, orange, or yellow. The reaction they cause is manifested by a burning sensation, soon followed by severe cramping which involves the muscles of the chest, abdomen, lumbar region and legs. Generalized symptoms also occur in the form of restlessness, headache, nausea and sweating. Neurotoxicity occurs, but none of the allergic reactions such as urticaria, wheezing, shortness of breath, and severe local swelling is noted. This condition is treated best by calcium gluconate and hyperimmune horse serum antivenom. Hot baths and sedation may be helpful.[1,8]

Prevention

Wasp nests should be removed after searching under the eaves, in carports, behind shutters, in shrubs and wood piles. They are destroyed by hosing or removing with a stick or broom handle, and should be sprayed once a day for two or three days to discourage rebuilding. Yellow jackets build in the ground, and the hole through which they emerge should be treated at night with gasoline and kerosene. Lye may also be applied but repeated use is necessary. Hornets, who build in shrubs or trees, should be removed by a flaming torch, and the nest should be clipped into a jar or pail and sprayed with an exterminator. Honey bees are removed by the above methods or by a bee keeper or by the fire department, if the hives cannot be reached.

Any sort of food will attract Hymenoptera so that outdoor cooking or eating is somewhat risky. Cleanliness about the garbage area and repeated spraying of patio and garage cans with insecticides will tend to keep the insects away. Gardening should be done very cautiously. Vines which conceal hives should be removed from the house.

Various perfumes, hair sprays, tonics and suntan lotions attract these insects. Floppy clothing, bright colors and flowery prints and black should be avoided. One should use light colors such as white, green, tan and khaki which do not antagonize or attract bees. One

should always wear shoes. Aimless kicking of a dead log may disturb the insects and cause severe swarming stings. Public trash baskets at state parks should be avoided. An insecticide bomb should be kept in the glove compartment of the car and be used should an insect fly into the car.

Flicking the stinger off the skin, or the use of tweezers from an emergency kit is beneficial in preventing further squeezing of the venom for the next two or three minutes into the site of the sting. A kit should be kept on hand consisting of a tourniquet, adrenalin, an isoproterenol spray, sublingual isoproterenol, an antihistamine, and a corticosteroid as well as tweezers. Several drug companies have made these kits available. They are beneficial and should be carried at all times, particularly by those who have generalized reactions.

It has been suggested that these emergency kits be carried not only by patients known to be allergic to insect stings, but also by those over 40 years of age who have outdoor jobs, and particularly those who are known to have heart disease.[2,3,6,7,8,9]

Hyposensitization

Hyposensitization is clearly beneficial in this type of problem. In approximately 90% of the people who have received the insect extract and were subsequently stung there has been a significant decrease in the severity of the reactions. It is felt now that hyposensitization should be continued for an indefinite period with a minimum of three years suggested. Protection has been shown to persist for years in some persons and to be lost in less than a year in others after hyposensitization has been discontinued.[4]

Each patient who has a history of significant insect sting reactions as evaluated by their clinical history should be hyposensitized. If a person has any type of generalized reaction, regardless of its severity or mildness, treatment is started. When a patient has a severe local immediate reaction which is quite large, treatment is started, and if a patient has a severe local, delayed and prolonged reaction treatment is a'so recommended.

An extract of whole body and venom sacs of bees, wasps, yellow jackets, and hornets is used. This mixture is for both skin testing and treatment because of the difficulty in identifying the insect which caused the reaction and because of the crossed antigenicity of the antigens themselves.

The patient is usually skin tested intradermally, preferably sequentially, to a very weak concentration starting with 1-1,000,000, 1-100,000, 1-10,000 after being previously scratch tested. If the scratch test is strongly positive, then the dilutions are made weaker. This is done in order to determine the reactivity of the patient, and to decide at which concentration to start therapy. The patient is started on injections at the minimal skin test dose reaction i.e., if a two plus or less reaction occurs at one of the above described concentrations, treatment is started at this level and is given twice a week for two or three weeks and then once a week until the end of warm weather. A reduction in concentration or dose should be made if any reactions occur. The dosage is built up gradually by 0.05 cc increments to a concentration of 1-10 or to the highest tolerated dose as measured by local reactions or systemic symptoms[4]. Following this, injections are given every two weeks, then every three weeks, and finally every four weeks. Some authors have recommended every five or six weeks and even every two months, but this method remains to be explored and investigated on a broader statistical basis. The treatment as described above may continue for an indefinite period but should be given for at least three years. The last two or two and a half years of hyposensitization could probably be on "booster type" schedule.

Hyposensitization against mosquito and flea bites may also be performed in this manner and is usually quite successful.

Summary and Conclusion

It is now known that approximately 50% of the patients who have severe generalized reactions have them without any warning. Once a person is sensitized to an insect sting, over 65% have increasingly severe reactions without hyposensitization. About one-third of the persons who are allergic to insect stings have a history of allergy.

Treatment of an insect sting reaction should consist of epinephrine, antihistamines, aminophyllin, isoproterenol, corticosteroids and local measures. Supportive treatment for shock and anoxia may also be indicated. Emergency kits containing the above drugs should be carried by all susceptible persons.

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Pulmonary Blastomycosis Complicating Miliary Tuberculosis

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The need for complete diagnoses and treatment efforts in associated diseases is reemphasized. A patient with miliary tuberculosis was found to have a superimposed Blastomycosis infection when his initial clinical response to treatment did not follow the anticipated course. Both diseases responded satisfactorily to combined antituberculous and Amphotericin-B therapy.

THE coexistence of two or more diseases is reported with increasing frequency in medical literature. The occurrence of tuberculosis in particular with silicosis, diabetes, bronchogenic carcinoma, histoplasmosis, and emphysema, is well documented.

In the literature are numerous examples of pulmonary tuberculosis coexistent with cutaneous blastomycosis, but the simultaneous occurrence of pulmonary blastomycosis and pulmonary tuberculosis appears to be infrequent or else not recorded. Recently Furcolow et al[1] reported 183 cases of blastomycosis from Kentucky with an associated incidence of tuberculosis of approximately 12.8%. In another series of 198 cases of blastomycosis[2] 10 had pulmonary tuberculosis.

The following is presented because of a number of unusual and interesting features.

Case Presentation

L. H., a 54 year old Caucasian male, was admitted to our hospital on 3-1-63 from another institution where sputum smears were reported positive for acid-fast bacilli. The history dated back some five months when the patient developed a sore throat with subsequent remission. He also complained of malaise, anorexia, dry cough, and a weight loss of 30 lbs. The past history was noncontributory, and there was no family history of or known contact with tuberculosis. The patient worked as a plant pathologist. On physical examination he appeared toxic but was not febrile, the skin was erythematous, and system evaluation was noncontributory. Blood pressure was 102/54.

Chest x-ray on admission (Fig. 1) revealed disseminated fine nodulation throughout both pulmonary fields suggestive of miliary tuberculosis. PPD intermediate strength, histoplasmin, blastomycin and coccidioidin skin tests were all negative. CBC was within normal limits apart from a hemoglobin of 12.4 grams. Urinalysis was unremarkable. Complement fixation for fungi was negative. Sputum smears and subsequently the cultures were all positive for Mycobacterium tuberculosis, suscepti-

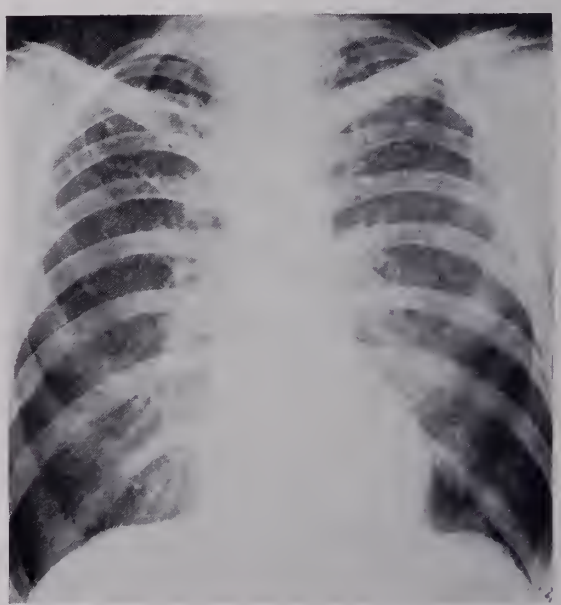


FIGURE 1. Admission chest x-ray (3-1-63) showing miliary lesions in both lungs. Sputum positive for M. tuberculosis.

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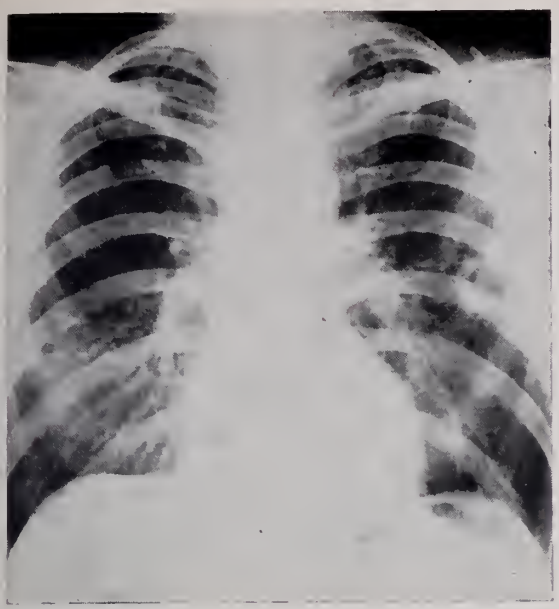


FIGURE 2. Chest x-ray 4-30-63, after approximately two months chemotherapy shows marked clearing of the miliary disease bilaterally, and the appearance of a thick-walled cavity in the left lower lung field.

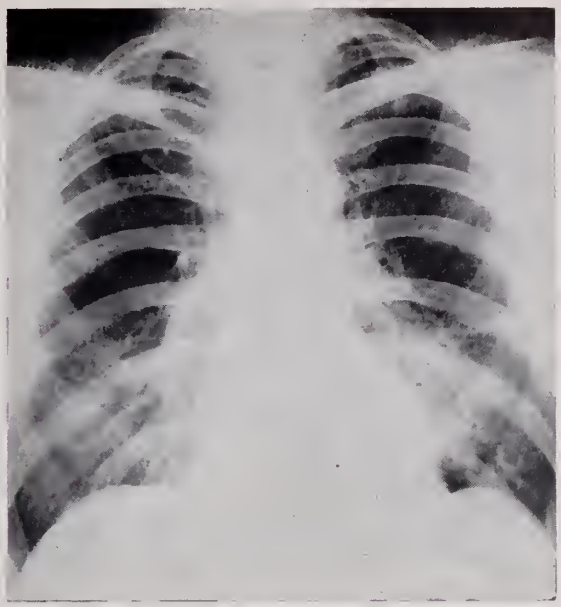


FIGURE 3. Out patient chest x-ray of 1-7-64 showing extensive clearing of the miliary lesions and closure of the cavity.

ble to Isoniazid and PAS, resistant to Streptomycin (10 mcg/ml).

Hospital Course

Because of the acute nature of the disease the patient was immediately started on intensive antimicrobial therapy consisting of Streptomycin 1 gram twice daily for the first few days and then 1 gram daily, Isoniazid 900 mgs. daily, PAS 12 grams daily, with Pyridoxine 50 mgs. daily. Other supportive measures were also instituted. Clinically the patient showed definite improvement, and examination on 4-1-63 (after one month of chemotherapy) showed some definite clearing of the disseminated infiltrative process in both lung fields; however, an area of rarefaction strongly suggestive of cavitation appeared on the left side opposite the fourth rib anteriorly. Because of this initial progress the patient was maintained on the same regimen.

Clinical improvement continued and a repeat chest x-ray on 4-30-63 showed further clearing of the miliary type lesions bilaterally, but there now was a definite thick-walled cavity in the left lower lung field (Fig. 2). About the middle of April the patient complained of gastrointestinal symptoms with gaseous distention, colicky pain and diarrhoea. Intolerance to PAS was suspected and various measures were taken to try to overcome this but the symptoms persisted. An x-ray of the abdomen showed numerous fluid levels in the intestine.

The symptoms improved but recurred intermittently. It was felt that certain features in this case could possibly be explained on the basis of disseminating tuberculosis; but one would expect tuberculosis under susceptible conditions to respond promptly to adequate treatment without any further spread of disease. With regard to the pulmonary lesions the miliary disease was responding as well and as fast as one would anticipate but the appearance of the cavity in the left lower lung field was unexpected in the usual primary course of tuberculosis chemotherapy.

These developments pointed to the possibility of a concurrent disease and accordingly a series of sputum examinations for fungi were submitted and the first five cultures were positive for blastomyces dermatitidis.

It was concluded that this patient had a superimposed disseminating blastomycosis infection although the blastomycin skin test and several complement fixation studies were negative. It is well known that in some cases one can actually find an active mycotic infection in the presence of a negative complement fixation and negative skin test.

Following a preliminary laboratory work-up the patient was started on Amphotericin-B treatment on 7-22-63. The initial dose of 15 mgs. was gradually increased to 50 mgs. three times a week intravenously. A total dosage of 2280 mgs. was given and 25 mgs. Hydrocortisone was included in each infusion to counter-

TABLE 1. LABORATORY DATA DURING AMPHOTERICIN-B THERAPY

		Pre-treatment 7-15-63	7-31-63	8-14-63	8-28-63	9-11-63	9-25-63	10-9-63	10-23-63	11-6-63	12-5-66
BLOOD	Hb (Gm %)	13.2	11.6	11.2	10.2	11.2	11.2	11.2	12.2	11.2	15.1
	WBC	9,100	9,150	9,100	8,600	10,650	11,200	15,250	14,000	14,000	11,900
	FBS (mg %)	87		94		108		82		80	
	BUN (mg %)	13		14		20.1		15		26	22
	Electrolytes - Na (meq/l)	145		155		147		143		146	141
	Electrolytes - K (meq/l)	4.7		5.2		4.9		5.2		5.5	4.7
	Electrolytes - Cl (meq/l)	100		120		116		100.2		103	103
	Cephalin flocculation 24 hr.	neg.		neg.		neg.		neg.		1+	
	Cephalin flocculation 48 hr.	neg.		1+		1+		neg.		2+	
	Total Bilirubin (mg %)	.40		.40		.40		.35		.50	
	BSP (% retention)	2.5									
	SGPT (units)	20									30
URINE	Albumin	-	-	-	-	-	-	-	-	-	
	Casts	-	-	-	-	-	1-2	-	-	-	
	Sugar	-	-	-	-	-	-	-	-	-	
	WBC	rare	0-3/hpf	rare	-	-	rare	4-5/hpf	3-4/hpf	0-3/hpf	
	RBC	-	-	-	-	-	-	-	-	-	
	S.G.	1.011	1.010	1.010	1.012	1.012	1.015	1.012	1.010	1.011	

act toxic and allergic phenomena. Following the institution of Amphotericin-B therapy the recent cavitary lesion in the left lung closed (Fig. 3) and the abdominal symptoms subsided completely without recurrence. Subsequent series of sputum examinations have been negative for blastomycosis up to the present and the sputum became negative for AFB in May 1963 after 3 months of antituberculous drugs. The combined treatment of both diseases was well tolerated and repeated laboratory work-up showed no major abnormality in hepatic or renal studies and only a slight decrease in hemoglobin (Table 1).

Patient was last seen on 1-31-67 (a three-year followup). He has remained well and working and bacteriologically negative. Sputum remains negative for fungi.

Discussion

The recognition of an association of diseases is of more than academic importance. In many instances one encounters a combination of diseases that are amenable to treatment, with appreciable benefits to the patient. It is also apparent that if only one disease is recognized and treated, the other entity may remain or progress unimpeded. Such a case would be tentatively considered a "treatment failure". Actually it would not be a failure as a combined form of treatment would be indicated, and the "failure" would simply be a reflection of an incomplete diagnosis.

The fungus diseases are today not uncommonly described as complications of pulmonary tuberculosis. Aspergillosis has long been known as a secondary invader of tuberculous cavities or bronchiectasis. The simultaneous occurrence of active or latent pulmonary histoplasmosis and tuberculosis has also been well documented[3,4]. Hall and Cooley[5] reported a case of pulmonary nocardiosis and tuberculosis, so diagnosed preoperatively. Allison et al.[6] published the first case of concomitant pulmonary histoplasmosis and blastomycosis diagnosed ante mortem. Stein[7] described coexisting coccidioidomycosis and tuberculosis and mentioned the possibility of the coccidioidal infection reactivating a dormant tuberculous lesion, as has been implicated in connection with histoplasmosis.

Similar observations on the concurrence of blastomycosis and tuberculosis are scarce in the literature. Feld and Cadden[8] mentioned two cases that were proved by culture. Kempter[9] described a case of tuberculosis coexisting with lung cancer and blastomycosis. The therapeutic response in our case during a total of eight months hospitalization was quite encouraging. Antimycobacterial drugs and Amphotericin-B were well tolerated and the latter

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Measles Vaccination Study in Hopkins County, Ky. – 1966†

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The status of measles immunization was studied in a group of children 12 to 15 months of age. In the best group, only about one-half had had the vaccine and in the "hardcore" group only one-third.

SURGEON General William Stewart has indicated that 1967 could be the year of measles eradication in the United States. The existence of an effective measles vaccine for several years, the presence of several programs through which vaccine can be administered at little or no expense to the individual and the presence of staff (particularly in the Health Department) to administer the vaccine should mean that eradication could be accomplished in a manner similar to the polio eradication movement of recent years. However some differences exist between the polio eradication program and the proposed measles eradication project, perhaps the major ones being (1) the necessity for an injection, (2) the possibility of mild reactions to the vaccine, and (3) the existence of two types of measles frequently confused by the public.

It has been a common health education—public health practice to write parents, urging that they have their children immunized for various diseases at the earliest appropriate time. The effect of such written encouragements is not always easy to assess and once patients have been urged to have a particular immunization, the survey results may differ if they are determined by mail as contrasted with a telephone call or home visit. Certainly the form of the letter urging immunization must be important and it would be helpful to know the most effective type letter to use: "urging" letter, "educational" letter, "threatening" letter, or some combination.

Because Hopkins County, Kentucky, wished to participate in the 1967 measles eradication project, it was decided to determine some of the factors bearing upon measles immunization in the recent past in this county. It was believed that by knowing these factors, plans for immunizing children could be formulated more rationally. For these reasons the present study was undertaken.

Methods

Children 12 to 15 months of age born in Hopkins County were selected and divided into two groups of about 100 each depending upon whether the birth number ended in an odd or even figure.

The experimental group (118) received a letter (see page 722) urging that immunization for measles be instituted and parents were reminded of the ill effects of measles. The letter was a standard form often used for these purposes. Controls (113) received nothing by mail. After a waiting period of exactly two months, adequate time for action following receipt of the letter, experimentals and controls were followed-up first by a stamped, self-addressed card requiring only a check mark showing results and then, if no results were obtained, by a telephone call where possible. Finally, a home visit was made by one of the authors (D.C.S.) when information was not forthcoming in another manner.

It was believed that approximately 100 children in each group would be sufficient to show statistical differences or at least trends according to the experiment. Children 12 months of age or older were selected since this is the age at which immunization against measles is recommended. Slight difference in the

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size of the two groups exists largely because of postnatal deaths.

Results

Table I refers only to the *response* or *no-response* of parents in the experimental and control groups. The two groups are very similar except that more controls had to be contacted by telephone; there was no difference, however, in the results of those who spontaneously returned their cards and those who were contacted by telephone. Overall, 10.4% of the letters (24/231) were unclaimed and these patients could not be followed-up further; 15.6% of parents (36/231) spontaneously returned their cards while 29.9% could be reached by telephone making a total of 45.5% who could be contacted from the office. A discouraging 44.1% (102/231) make no response to the inquiry letter but obviously received it since it was registered and not returned; they had no listed telephone at which they could be reached.

TABLE I

Response Or Lack of Response By Parents To Inquiry Concerning Measles Immunization of Their Children. By Experimentals & Controls*

Hopkins County, Kentucky - 1966

	Response		No Response	Letters Unclaimed	Totals
	Returned Cards	Contacted By Telephone			
Experimental (118)	22	30	53	13	118
Controls (113)	14	39	49	11	113
Totals	36	69	102	24	231

* Experimentals = Those previously urged by Health Dept. letter to have measles immunization
Controls = No urging

Table II refers to measles and measles vaccine in the 105 persons in the *response* group. As shown, there are essentially no differences in the experimental and the control groups. The overall figure for the *response* group shows 55.2% (58/105) of the group had had the vaccine; 10.5% (11/105) had had the disease making a total of 65.7% who were "protected". A small number of parents (6.7%-7/105) were uncertain as to their children's status with respect to measles and the remaining 27.6% (29/105) by their own admission had unprotected children susceptible to the disease. The family physicians' records could be examined in all cases and verified not only that the child *had indeed had* the vaccine in

TABLE II

Answers (by telephone and card) of Response Group With Respect to Having Had Measles or Measles Vaccine According to Parents. By Experimentals and Controls.*

Hopkins County, Kentucky - 1966

	Had Vaccine	Had Measles	Had Neither Vaccine nor Measles	Uncertain	Totals
Experimentals	29 (27)	6	13 (12)	4	52
Controls	29 (24)	5	16 (15)	3	53
Totals	58 (51)	11	29 (27)	7	105

* Same as Table I
() = Verified by physicians' records

51 of 58 cases but that in 27 of 29 cases the parent was correct in stating that the child *had not had* the vaccine.

Table III shows the results of the *no-response* group who were visited at home. Again, differences between experimentals and controls are not great enough to indicate any trends. 5.8% (6/102) indicated they had had measles and 31.3% (32/102) indicated they had had the vaccine. 40.1% (41/102) had had neither vaccine nor measles and were thus "unprotected". Despite the fact that the initial letter urging immunization was received by the parent, 10.8% (11/102) of the houses could not be located and 11.7% of the subjects (12/102) had moved without leaving forwarding addresses.

Table IV is a summary table showing at the time of the study how many children were "protected" and how many "unprotected" insofar as having had measles or the vaccine. Of course, no information is available for those 24 who had unclaimed letters; unknown results are high in the *no-response* group due to moves or unsuccessful attempts to locate the houses. For those in both the *response* and *no-response* groups who could be located, the *response* group showed the greatest protection almost two-thirds—(65.7%), while the *no-response* group demonstrated protection in just over one-third—(37.2%). If one looks at the

TABLE III

Answers of No Response Group With Respect to Having Had Measles Or Measles Vaccine According to A Later Interview With The Parents. By Experimentals And Controls.*

Hopkins County, Kentucky - 1966

	Visited (At home = 72; at other places = 7)			Not Visited		Totals
	Had Vaccine	Had Measles	Had Neither Measles nor Vaccine	Moved	Unable to Locate House	
Experimentals	13 (8)	3	23 (20)	9	5	53
Controls	19 (13)	3	18 (18)	3	6	49
Totals	32 (21)	6	41 (38)	12	11	102

* Same as Table I
() = Verified by physicians' records

TABLE IV

Summary Table Indicating Measles Protection in Children Age 12-15 Mos. By Response Group and Total.

Hopkins County, Kentucky - 1966

	Response Group	No Response Group	Unclaimed Letters	Total All Groups
Protected*	69 65.7%	38 37.2%		107 46.3%
Unprotected	29 27.6%	41 41.1%		70 30.3%
Unknown	7 6.7%	23 22.5%	24	54 23.3%
Total Each Group	105 100%	102 100%	24	231 99.9%

* Protected = Had Vaccine Or Measles

total for all groups without respect to *response* or *no-response,* the results appear as in the final column: approximately one-fourth (23.3%) cannot be followed-up, approximately one-third (30.2%) are definitely known to be "unprotected" and just under one-half (46.3%) are known to be "protected".

Interpretation and Conclusions

At best, only about one-half of the children in Hopkins County 12 to 15 months of age are protected against measles and the remainder represents a "hard-core" group who can only be contacted by repeated visits or are not traceable. Since this was a retrospective study, some decrease in follow-up of patients is to be expected over a prospective study where information concerning addresses would be more reliable. It is to be hoped that rates of protection would be greater in older children but the older child generally is less seriously affected by measles. It would appear that standard techniques (including the sending of letters) have not been adequate for acquainting the public with the need for measles immunization.

Even the use of a special letter as in this study did not affect the recipients any differently from those who did not receive it. No test of different types of letters was made and other letters might have been more effective. It is conceivable that a general reluctance to give one's child a "shot" might affect the results but again this was not investigated. Measles may not engender enough fear in the population to expect measles immunization results much better than presented in this age group. Requiring measles immunization for school entrance might slowly and eventually eradicate the disease, but if no further campaigns are undertaken, the results reported here indicate that a rather large pool of children between 15 months and 6 years of age will remain susceptible to measles and its complications.

Unless a different kind of urging letter can be devised which is more effective in inducing immunizations, it might be well to direct money towards personnel who can maintain surveillance of children as they are born and who can obtain earlier and more complete follow-up particularly of the "hard-core" group. It might also be that adoption of measles vaccination as a school requirement will produce some better results indirectly in the younger age groups. Once measles has been eradicated it will be necessary to keep immunization levels high in order to prevent epidemic as well as sporadic measles from occurring.

It was gratifying to see that when a parent responded in whatever manner, the results generally could be relied upon as indicative of the child's true state of immunization as verified by physicians' records. Upon reflection, it is not surprising that more parents were correct in stating their child *had not had* measles vaccine (65 out of 70—93%) than were correct in stating their child *had had* the vaccine (72 out of 90—80%). (p value less than .01) A parent appears more likely to know definitely that an action has not been taken than that it has.

Summary

1. Parents of children 12 to 15 months of age were divided, on the basis of odd or even birth number, into two groups: Experimentals —(118) who were sent a letter urging measles immunization; Controls—(113) who were sent nothing. Two months later both groups were assessed for status of measles immunization.

2. The letter had no discernible effect in increasing the number immunized in the experimental group over that in the control group.

3. Overall, 23.3% of the children could not be located, 30.3% were unprotected from measles (had not had the disease or vaccine) and 46.3% were protected (had had vaccine or measles).

4. In a subgroup *(response group)* which could be traced by the cards returned and by telephone, results showed: 6.7% uncertain of immunization status, 27.6% unprotected and 65.7% protected. In the subgroup requiring

(Continued on Page 722)



when he just can't sleep

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ndications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

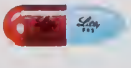
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

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SPECIAL ARTICLES

Not In Mediocrity, But In Leadership†

Paul I. Hoagland, M.D.*

MAY I quote the 31st President of the United States who, on his 89th birthday, said: 'Recently, in my opinion, there has been too much talk of the common man. It has been dinned into us that this is the Century of the Common Man. The idea seems to be that the Common Man has come into his own at last.

"Thus we are in danger of developing a cult of the Common Man, which means a cult of mediocrity. But there is at least one hopeful sign: I have never been able to find out who this Common Man is! In fact, most Americans, and especially women will get mad and fight if you try calling them "common"!

"This is hopeful because it shows that most people are holding fast to an essential fact in American life. We believe in equal opportunity for all, but we know that this includes the opportunity to rise to leadership—in other words, to be uncommon.

"Let us remember that the great advances have not been brought about by mediocre men and women. They were brought about by distinctly uncommon people with vital sparks of leadership. Many of the great leaders were, it is true, of humble origin, but that alone was not their greatness.

"It is a curious fact that when you get sick you want an uncommon doctor; if your car breaks down you want an uncommonly good mechanic; when we get into war we want dreadfully an uncommon admiral and an uncommon general.

"I have never met a father and mother who did not want their children to grow up to be uncommon men and women. May it always be so.

"For the future of America rests not in mediocrity, but in the constant renewal of leadership in every phase of our national life."

Herbert Hoover was, indeed, an uncommon man, as was so attested by his Alma Mater when it recently bestowed upon him, posthumously, its first Uncommon Man Award.

"Not in Mediocrity, but in Leadership"—this must be the theme of our thinking, Blue Shield thinking, the thinking of organized medicine, as it has never been before. Doctors have been segmented and confused by Medicare. They are, or should be, looking to their economic arm, Blue Shield, for leadership and guidance. Can we provide it? Of course! But we must have the support of all physicians.

Introduction

Like most medically sponsored innovations in the field of economics, Blue Shield was born out of necessity in the early thirties when physicians began establishing plans as a means of helping less fortunate patients pay for their medical care. It rose as our answer to the threat of government medicine at a time when the existing commercial insurance carriers refused to assume the risk. We heard such quotations as: "uninsurable," "impractical" "won't sell". And now look at the voluntary health insurance industry, a fiercely competitive, thriving business that provides coverage to over 100 million Americans.

In spite of this we heard such defeatist statements as: "Blue Shield has outlived its usefulness", "The voluntary prepayment system is dead". These are negativistic ghosts that must be laid to rest.

The theme of the program conference of NABSP in October was "A look back—and a look ahead". Let us pursue this trend for a few minutes and see up with what we come.

Historically

Granting you that California Physicians Service, CPS-Blue Shield, got its original impetus from the Bureaus in this area, let us also concede that this was the first state-wide plan of any size and look back on its history. This is important because 70% of the doctors we talk to today don't really know about the problems of the thirties, the great depression, what it was like to be lucky to collect 50% of your fees.

I was a student at Stanford in the height of the depression and lucky to be able to be there! The father of one of my closest friends, a surgeon, had warned us not to study medicine—that it would soon be socialized, and that this would start in California. (He was almost right!) His son, my friend, heeded this advice and is a stockbroker in San Francisco. I was not to be disuaded, but like most medical students, was a bit apprehensive and pretty liberal in my thinking. (Or should we say broadminded.) I weighed about 127 pounds, and now, 30 years later,

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†*Presented at the Seventeenth Annual Interim Meeting of the Kentucky Medical Association, April 20, 1967*

**President, National Association of Blue Shield Plans, residing in Pasadena, California*

I am reminded that middle age may be defined as "when the broad mind and narrow waist start to change places!" I am still trying to be broadminded, or I wouldn't be here today!

In 1938 California's governor, Culbert Olson, a Democrat, proposed a scheme of socialized medicine in California that would have passed, but for the efforts of the California Medical Association—under the able leadership of Ray Lyman Wilbur, Alson Kilgore, Tom Kelly, and others—their efforts to provide this much needed care, through a doctor-sponsored non-profit prepayment mechanism, that so impressed the legislature that they sheltered CPS under the protective umbrella of the attorney general as an organization devoted to social welfare and therefore entitled to exemption from dues-premium taxation!

For 25 years this was the answer to the surgeon who had predicted that medicine would soon be socialized in California. Let no one doubt that the existence of CPS-Blue Shield was the prime reason for the defeat of another scheme proposed in 1945 by Governor Earl Warren, a Republican, in response to the demands of CIO.

In its early years CPS made mistakes: in its infancy it was able to pay as little as 15¢ on the dollar, and yet the doctors supported it!

Down through the years experience forced the introduction of controls—deductibles (the two-visit deductible made CPS solvent!), various types of coinsurance, fee schedules—all of which made the costs of health services predictable, and the programs actuarially sound. To protect doctor relationships, and, I suppose, the time honored "Robin Hood" philosophy of medical charges, income ceilings were introduced. These same fee schedules and income ceilings which had to exist side by side for bargaining purposes—after all, we couldn't raise fees on the one hand without income ceilings on the other—became a burr under our saddle blanket that had to be eliminated if we were to continue to enjoy the support of the profession!

In the past 10 years all of this has been refined by the introduction and implementation of Relative Value Studies, the establishment of Fee Complaint Committees, and utilization review to the point that the voluntary system has become sophisticated and mature.

During all these years of development and expansion of the voluntary prepayment mechanism, mother AMA has been typically inconsistent. It took years for her to officially recognize her economic arm and its potential value to organized medicine. Blue Shield's struggles with the AMA were no less difficult than some of her present problems with insurance commissioners and HEW.

A Look Ahead

Tremendous changes in the practice of clinical medicine have challenged the whole voluntary mechanism and put a tremendous strain on the doctor image, the doctor-patient relationship, and the whole time-honored fee-for-service method of payment. The passage of the Social Security Amendments of 1965 has placed Blue Shield in an entirely unfamiliar role: 33 Blue Shield plans are serving as part B carriers servicing approximately 60% of the aged enrolled under Part B of Title XVIII. Blue Shield has met these challenges head-on and taken the lead.

I have already made the statement that doctors have been confused and segmented by Medicare and are looking for leadership and guidance. Blue Shield has done and is doing its best to provide it.

At the National Level NABSP has reviewed the RVSs and/or plans best fee schedules and summarized them all in its PSI. This made possible the introduction and successful implementation of Prevailing Fee Programs. Commercial carriers, in the meantime, had successfully experimented with the "Usual and Customary" approach in their major medical programs behind the protection of large deductibles and coinsurance.

Whether we are using the terms "Reasonable," "Usual and Customary", 'Prevailing", or you name it, we are talking about the same thing—no matter how thin you slice it! This is the biggest advance in the history of Blue Shield. The "Usual and Customary" approach could solve the problems of the national accounts (motors, steel, etc), who are demanding uniform benefits, guaranteed full service benefits (full payment), and no income ceilings. And this approach works—at any level—even Title XIX—PAMCP. Mr. Thomas Paton, President of CPS, was able to avert a crisis and demonstrate to the satisfaction of the Department of Finance in California that CPS had actually saved them money by paying Usual and Customary in its Title XIX programs in contrast to the IAC program paying fixed fees on a $5.50 coefficient on '64 RVS! This is just one area in which Blue Shield *has* provided leadership.

What is it doing now? NABSP has established excellent rapport and liaison with HEW. It has provided frequent central and regional meetings offering guidance and assistance to its part B carrier Plans. It speaks to Baltimore from strength and a Pat hand—provided it can demonstrate medical society and physician support.

Still there are those—and many of them—that say: "So what, Paul, we still have Medicare don't we?" Let's just take a look at Medicare—a hard and impartial and broadminded one: Would we have had the "Usual Fee and Reasonable Cost" approach but for the guidance and experience of the Blues? Would we have had a choice of assignment except for the successful example set by the voluntary system? Does anyone for a minute think we would still have the traditional free choice doctor patient relationship, and fee for service principle but for the efforts of the voluntary system in general initiated by Blue Shield? Does a look ahead, in view of the facts that we are facing today, suggest that, in addition to our regular voluntary prepaid programs, implementation of these government programs is an ultimate destiny of Blue Shield? and Blue Cross?

In the United Kingdom, where the opposite approach to socialization of medicine has been true for years, we now see almost 7 million of their 40 million people carrying an entirely separate, not supplementary, but separate coverage for medical services guaranteeing free choice of physicians, out-

(Continued on Page 722)

EDITORIALS

Addiction Among Physicians

IT WAS about 1850 that the hypodermic needle came into vogue and with it the use of narcotics for the relief of pain became general. The addicting properties of morphine, heroin, cocaine were not generally feared and no warning nor prohibitions against their use were made. By 1900 narcotic drugs were more widely employed and in 1910 it was estimated there were 200,000 addicts in the United States or one in every 400 of the entire population. Narcotic addiction had become a national problem and measures were undertaken to control it.

The Pure Food and Drug Act was passed in 1906. In 1914 the Harrison Narcotic Act was established and its implementation became effective after World War I. In 1930 the Federal Bureau of Narcotics was created to regulate and control the use of these drugs. In the decade 1920-30 awareness of the dangers of addiction led to the clinic plan or "ambulatory treatment," administering drugs to addicts as needed. Experience in the United States and other countries with this plan showed it to be a dismal failure, increasing rather than lessening the use of narcotics.

In 1935 U. S. Public Health facilities were established in Lexington, Kentucky and in Ft. Worth, Texas with 2,000 bed capacity for the study and treatment of addiction. These institutions have helped in the rehabilitation of a great many useful citizens and have provided the best scientific information on addiction as a basis for our present and future programs.

National and State Legislation has been improved in recent years. The Narcotic Addict Rehabilitation Act of 1966, passed by the 89th Congress November 8, provided for civil commitment and treatment instead of criminal prosecution of addicts. Kentucky's famous "Blue Grass Law" long preceding the national measure had provided for the commitment of habitual users of narcotics to institutions for treatment in lieu of serving a jail sentence. This law was further amended by the 1966 Legislature making it a crime to use or be under the inlfuence of narcotics within the Commonwealth of Kentucky for other than a legitimate medical reason.

By 1935 despite the increase in population over a 20 year period it was estimated that there were 60,000 addicts in the United States or a ratio of about 1:2,000. In 1945 the number was estimated at 20,000. From 1945 to 1950 due to several known factors the number had again risen to 60,000 but since then, with more effective methods of control, there has been a steady decline and more effective means of rehabilitation have been practiced.

Addiction to the use of narcotic drugs is particularly high among physicians and nurses —one estimate is 100 times greater than in the general population. At any rate with physician manpower so critical the loss of a few, or a single one, in these professions poses a special problem which concerns us all. The Chief of our own Narcotic Bureau in Kentucky estimates that one in every hundred physicians has a narcotic problem at some time in his practice. Fortunately, however, it is felt that the probability of complete rehabilitation among physician addicts is far brighter than in the general population.

In the last century and the beginning of this, opium, morphine, cocaine, heroin were the principal drugs of addicts. Our own Narcotic Bureau now lists five different groups of drugs totalling 60 in all now covered by our Narcotic laws. Among these Meperedine, or Demerol, is by far the most frequently used. It is estimated that perhaps 90 per cent of physician and nurse addicts have fallen victims

to this drug and continue to use it by preference despite its unpleasant and treacherous characteristics. It is claimed by some that rehabilitation from Demerol addiction is more probable than from other narcotics, but in actual experience this seems questionable.

Prior to 1954 the strong addicting properties of Demerol were not widely known. It is a synthetic drug and was first introduced without full warning as to its potential danger. It is probably for this reason that it gained such wide use among physicians and nurses as a pain relieving medication. Solomon Garb, M.D., of the pharmacology department of the University of Missouri Medical School wrote an article in Nursing Outlook November, 1965 entitled "Narcotic Addiction in Nurses and Doctors." He regards Demerol as a non-essential drug and advises serious consideration of its removal from the market. Reporting on the properties of Demerol Doctors Isbell and Fraser are quoted as stating, "Altho physical dependence on Meperidine is milder than dependence on Morphine the toxic effects of the drug are so pronounced that addiction to this compound is even more undesirable than is addiction to Morphine." Arthur Grollman, M.D., in his Pharmacology and Therapeutics, states that "Addiction to Meperidine is much less amenable to treatment than is addiction to Morphine."

Narcotic addiction is so often combined with or the end product of other evils that it can seldom be dealt with as an entirely separate issue. The physician most often begins its use to sustain or tide him over a period of overwork, insomnia, emotional crisis or pain in order to continue his work, not always from a selfish impulse. Seldom is he engaged in illicit drug traffic for gain. The use of phenobarbital or other harmful drugs and excessive alcohol often precede or accompany the development of addiction. Ordinary addicts, especially among the young, have acquired the habit in an effort to experience a peculiar thrill or kick and are very often inadequate personalities or mentally ill. This is seldom true among physicians.

Unfortunately, the physician addict often has induced or allowed his wife, secretary, or office nurse to acquire the habit so that rehabilitation becomes a multiple problem.

The administration of our Narcotic Act and the discipline of physicians in the state are functions of the State Board of Health. Constantly alert to detect drug abuse individually and commercially, our State Bureau of Narcotics provides evidence of violations and with the Legal Department suggests the manner of disciplinary action. In accordance with our previous and recently amended laws, attempt at treatment and rehabilitation rather than punishment is always made. It is very encouraging that these efforts are so often fruitful in preserving or restoring the physician to useful work. Those in charge of the Narcotic Farm at Lexington report a very much better percentage of rehabilitation among physician addicts than others. Unfortunately, however, the recurrence rate is always high and physicians appearing before the Board of Health for help are often repeaters.

It must also be admitted that the number of drug addicts is perhaps twice as high as that documented and recorded and, with the widespread use of amphetamines, L.S.D. and alcohol, newly formed and unknown victims probably outnumber those under observation. The problem remains always with us and constant vigilance, tact and effort are required to control and diminish this social, moral and depleting factor in our own profession.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Prominent Guest Speakers To Discuss Trauma At Opening Session Of 1967 KMA Annual Meeting Scientific Program September 26

At the opening session of the 1967 KMA Annual Meeting Scientific Program, three prominent speakers will explore the topic of "Trauma." They are Theodore A. Fox, M.D., Chicago, guest of the Kentucky Orthopaedic Society; John Rankin, M.D., Madison, Wisconsin, guest of the Kentucky Chapter, American College of Chest Physicians; and William C. Kranz, D.M.D., Lexington, the Association's guest from the Kentucky Dental Association.

Other highlights of the Annual Meeting will include a "What's New Symposium", featuring five physicians who will discuss the latest developments in their fields of medicine, and meetings of 16 specialty groups.

Doctor Fox, an orthopaedic surgeon who will speak on "Internal Derangement of the Knee," is chairman of the Subcommittee on Athletic Injuries of the Chicago Committee on Trauma, American College of Surgeons. He graduated from the Rush Medical College of the University of Chica o in 1937 and is an associate professor of orthopaedic surgery at the University of Illinois College of Medicine.



Doctor Fox

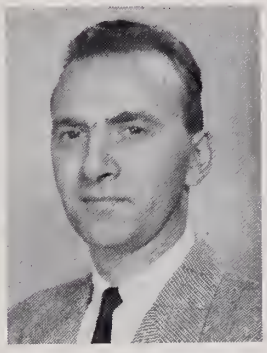
Doctor Fox is the editor of the "Manual of Orthopaedic Surgery." He is a member of the American Academy of Orthopaedic Surgeons, a fellow of the American College of Surgeons, and a diplomate on the American Board of Orthopaedic Surgery.

Doctor Rankin, a native of Glasgow, Scotland, attended the University of Glasgow Medical School and graduated from the University of Wisconsin Medical School in 1945. Since that time Doctor Rankin has taught in both Scotland and Wisconsin, has served on numerous councils and committees at the University of Wisconsin, and is presently practicing in Madison at University Hospitals.

He is a member of the Royal College of Physicians (London), the Royal College of Physicians and Surgeons (Glasgow), the American Thoracic Society, the American College of Physicians, and many other professional societies. His topic for the "Trauma" session has not yet been announced.



Doctor Kranz



Doctor Rankin

Doctor Kranz, an oral surgeon, will discuss "Oral-Facial Trauma" at the meeting. He graduated from the University of Louisville School of Dentistry in 1951 and was recently named president-elect of the Kentucky Dental Association. He is currently president of the Kentucky Society of Oral Surgeons, a past president of the Blue Grass Dental Society, and a member of the American and Southeastern Societies of Oral Surgeons.

The physicians scheduled to speak during the "What's New Symposium" Wednesday morning, September 27, and their topics are Beverly T. Towery, M.D., Louisville, Internal Medicine; John Greene, M.D., Lexington, Obstetrics and Gynecology; Vernon L. James, Jr., M.D., Lexington, Pediatrics; Donald R. Kmetz, M.D., Louisville, Pathology; and Warren M. Cox, M.D., Louisville, Psychiatry.

The 16 specialty groups will hold their meetings on Tuesday afternoon, September 26 and Thursday afternoon, September 28. The complete program for the Annual Meeting will be published in the August issue.

1967 AMA MEETING

The 1967 American Medical Association meeting was in progress at the time this issue of The Journal went to press. Complete information will be carried in the August issue.

Board Meeting Called To Discuss Title XIX Recommendations

Recommendations of the Technical Advisory Committee to the Governor's Advisory Council on Medical Assistance relating to the operation of Title XIX under PL89-97 were considered at a called meeting of the Board of Trustees of KMA Sunday, June 11, in Louisville.

The Board voted to oppose the establishment of the providing of drugs under Medicare by generic prescription. It also took exception to the proposed x-ray and laboratory fee schedules and voted to urge that the usual and customary concept be approved as a method of payment for these services.

One of the prime purposes of the meeting was to give consideration to how information derived from the Blue Shield usual and customary fee survey as provided for by Resolution A, passed in 1966 by the KMA House of Delegates, should be used. Resolution A had provided for the confidentiality of this material and had given the Board of Trustees the authority to release it as it felt indicated.

After full consideration, the Board passed the following motion: "RESOLVED that the KMA Board of Trustees authorize the KMA Executive Committee and Kentucky Physicians Mutual, Inc. (Blue Shield) to release to the Kentucky Department of Health the statistical average of fees studied, by procedure, for the purpose of doing a feasibility study to determine the predicted cost of covered services under Title XIX in Kentucky if the benefits are provided and services paid under the usual, customary and reasonable concept."

Attention was called to the fact that all but four of the 28 Board members were present with only four days notice of the meeting.

President's Luncheon To Feature Dr. Dallis, Comic Strip Author

Nicholas P. Dallis, M.D., Scottsdale, Arizona, author of the Rex Morgan, M.D., comic strip, will be the keynote speaker at the President's Luncheon during the 1967 KMA Annual Meeting. The luncheon will begin at 11:50 a.m., September 27, in the Flag Room of the Kentucky Hotel.



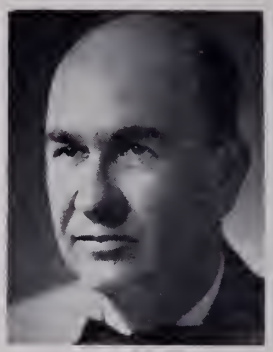
Doctor Dallis

Doctor Dallis will speak of "Life Among the Comic Strip Heroes and Heroines." In addition to Rex Morgan, M.D., created in 1948, he is the author of Judge Parker, created in 1952, and Apartment 3-G, created in 1961.

Doctor Dallis graduated from Temple University School of Medicine in 1938 and practiced psychiatry from 1945 until 1959 in Toledo, Ohio, when he discontinued his practice to devote full time to authorship of the comic strips.

Dr. Simpson Resigns From Council; Board Elects Dr. Seeley

Gaithel L. Simpson, M.D., Greenville, who has served as the representative on and chairman of the Governor's Advisory Council for Medical Assistance since its inception in 1960, has resigned.



Doctor Simpson



Doctor Seeley

Ellsworth C. Seeley, M.D., London, former president of the Kentucky Academy of General Practice who is active in local civic and medical affairs, was elected by the KMA Board of Trustees to succeed Doctor Simpson.

Before choosing Doctor Seeley as Doctor Simpson's replacement, the Board passed the following resolution: "RESOLVED, that this Board of Trustees on behalf of all KMA members expresses its deep admiration for Doctor Simpson's leadership and its full appreciation for the very unselfish and effective service that Doctor Simpson has rendered to the program and to the people and to the profession."

The Council is made up of a member from each of the five vendors of service which are physicians, hospitals, dentists, nurses and pharmacists, plus the Commissioner of Health, the Commissioner of the Department of Economic Security and four representatives of the public.

The Council aids the Department of Health and Economic Security on the administration of Title XIX programs under PL89-97.

Dr. Gardner on SAMA Board

Hoyt D. Gardner, M.D., Louisville, has been appointed by the AMA Board of Trustees to serve on the seven-man advisory board of the Student American Medical Association.

For several years Doctor Gardner, who is also secretary-treasurer of AMPAC, has served as the KMA representative on the advisory committee to the University of Louisville chatper of SAMA.

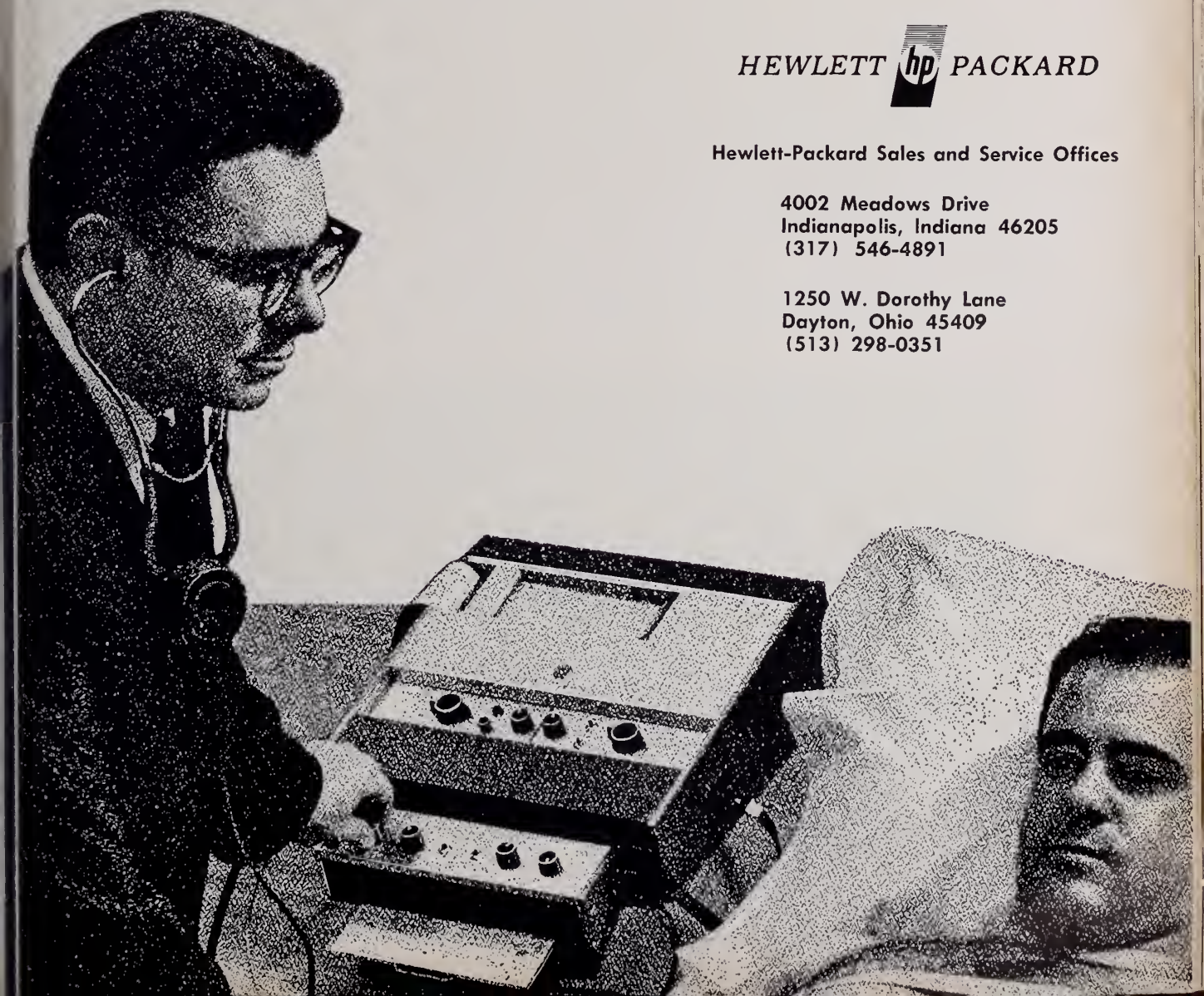
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. . . easily and quickly recorded on your office cardiograph

Auscultation and phonocardiography should complement each other in your clinical diagnoses — the former by helping you assess the musical and non-musical character of sounds and murmurs, frequency composition and variations . . . the latter by pinpointing the precise beginning and ending of sounds and murmurs within the cardiac cycle. Chart tracings of sounds, for example, may help identify points of occurrence and duration characteristic of certain innocent and pathologic murmurs . . . delineate the delay and first sound accentuation in mitral stenosis . . . or isolate the typically high-pitched murmur between the first and second sounds in aortic stenosis, which might otherwise appear pansystolic because of the low or inaudible intensity of the second sound. To further aid the precise determination of timing of sounds and murmurs, *combined ECG-PCG recording* will clearly reveal the location of the sound within the cardiac cycle. The Hewlett-Packard 1506A Heart Sound Amplifier enables you to do just that — in conjunction with a 500 Viso cardiograph or other 2-speed instrument with adequate frequency response. By electronically measuring and sampling the heart sound signal at a frequency within the Viso's recording capability, the 1506A permits diagnostic-quality PCG's to be recorded by the 500 Viso.

The compact, self-powered Amplifier clips to the front of your 500 Viso, allowing diagnostic PCG's, ECG's, or the PCG superimposed on the ECG, to be recorded. Switch-selected filter positions of 50, 100, 250 and 500 Hz (cps) permit excellent recording clarity and separation of the frequency range of interest. In addition, the Amplifier is supplied with an Audiophone to give you a highly efficient electronic stethoscope, with separate controls for listening and recording. (As a teaching tool, the Amplifier and ECG let the user *see* the sounds recorded, *hear* them, and correlate the two with the ECG.)

Contact your local HP medical instrumentation specialist for complete technical details of the 1506A Heart Sound Amplifier — $450 with microphone, audiophone and cable, FOB Waltham, Mass., Cont. U.S. Hewlett-Packard Company, Sanborn Division, Waltham, Mass. 02154. In Europe: HPSA, 54 Route des Acacias, Geneva. 17754



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Following repeated rounds of applause during their 30-minute performance at the Fifth Annual AMPAC Workshop in Washington, D.C., Saturday evening, June 3, the KEMPAC Kuties, physicians wives from Whitley County, were given a standing ovation by 500 enthusiastic attendants. Pictured during their performance from left to right are Mrs. Gene Scott, Mrs. B. H. Wells, Mrs. Harold Barton, Mrs. Harry Hamilton, Mrs. Arthur Holmes and Mrs. Dobson Pitman. Mrs. Keith Smith (not shown) is the accompanist for the Kuties.

Largest Ky. Delegation Attends Annual AMPAC Workshop

The largest Kentucky delegation in history and one of the largest of any state attended the Fifth Annual AMPAC Workshop June 3 and 4 at the Sheraton Park Hotel, Washington, D.C. The 22 Kentucky participants joined with more than 500 others to hear speeches by experts in the field of politics during the two-day program.

One of the features of the meeting was a panel moderated by Hoyt D. Gardner, M.D., Louisville, secretary-treasurer of the AMPAC Board of Directors. The panel, composed of two Republican and two Democratic senators and congressmen, included George Murphy, California, Walter F. Mondale, Minnesota, Bob Wilson, California, and Don Fuqua, Florida.

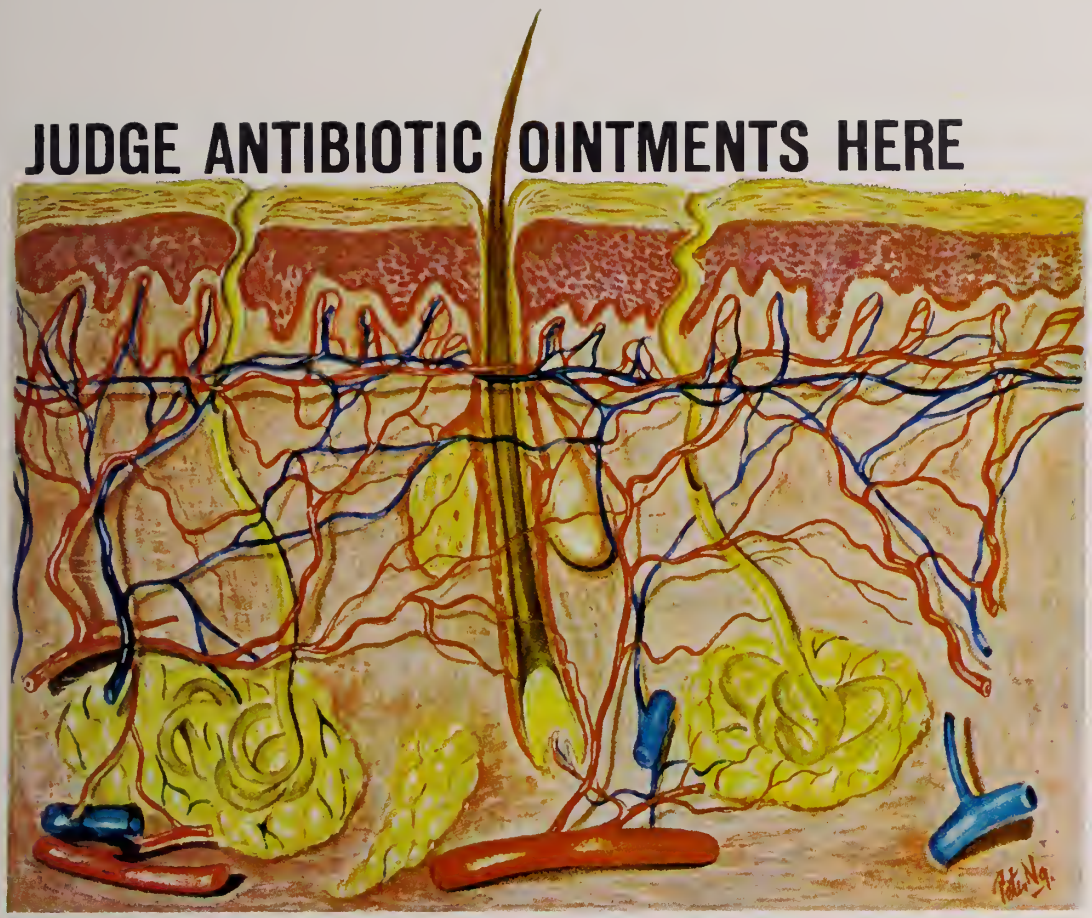
The KEMPAC Kuties, physicians wives from Whitley County, gave an outstanding performance which was enthusiastically received by the attendants at the June 3 dinner. Mrs. Dobson Pitman provided the choreography and wrote the music for the performance of the Kuties who had previously entertained with a skit at the 1966 KEMPAC banquet.

The Kentucky delegates, led by John C. Quertermous, M.D., chairman of the board of directors of KEMPAC, were Harold B. Barton, M.D. and Mrs. Barton, George F. Brockman, M.D., James B. Cox, M.D., Brian P. Geo hegan, M.D., Cecil Grumbles, M.D., Mrs. Harry Hamilton, Mrs. Arthur S. Holmes, Mrs. Charles C. Kissinger, C. Kenneth Peters, M.D. and Mrs. Peters, Dobson Pitman, M.D. and Mrs. Pitman, Mr. J. P. Sanford, Carl Scott, M.D., Mrs. Gene Scott, Mrs. Keith Smith, David B. Stevens, M.D., B. H. Wells, M.D. and Mrs. Wells, and William Wyatt, M.D.



Most of Kentucky's 22 delegates were present when the above picture was taken at the luncheon closing the Fifth Annual AMPAC Workshop June 3 and 4 at Sheraton Park Hotel, Washington, D.C. Among those delegates not included in this picture are John C. Quertermous, M.D., chairman of the KEMPAC Board, who was called home for an emergency, and Mrs. Charles C. Kissinger whose flight left minutes before the luncheon. (See accompanying story for complete list of Kentucky delegates.)

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Why these 7 patients wit
moderate to severe anxie
may respond better to Mella



1. The agitated patient.
Anxiety—particularly that beyon
range of minor tranquilizers-
quently is expressed as gross r
restlessness, fidgetiness and pur
less movements, and may erupt
aggressive behavior. Mellaril i
most a specific for those pat
whose anxiety follows such a pat



he psychosomatic patient.

family physician is rarely given diagnostic luxury of a classic, ook "anxiety state." Most often ust probe for anxiety masked by ictional disorder—or which exac-tes a somatic problem. Double- evaluations have demonstrated Mellaril can be a significant ad- in the treatment of such patients.



he patient under ational stress.

ril helps the patient deal with es of everyday life. Nonhabitu-, it can be given for extended pe- of time. It does not "separate" atient from practical problems pressures, does not induce eupho- r a fuzziness which can compro- e the ability to cope with reali- es. Rather, it helps the patient move more competently in his daily world by eliminating use-less tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


Bartholin's gland
Periurethral glands
Cervical gland
Flagyl.....
brand of
metronidazole
Seminal vesicles
Bladder
Prostate gland

estroys
richomonads
Wherever
hey Are

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

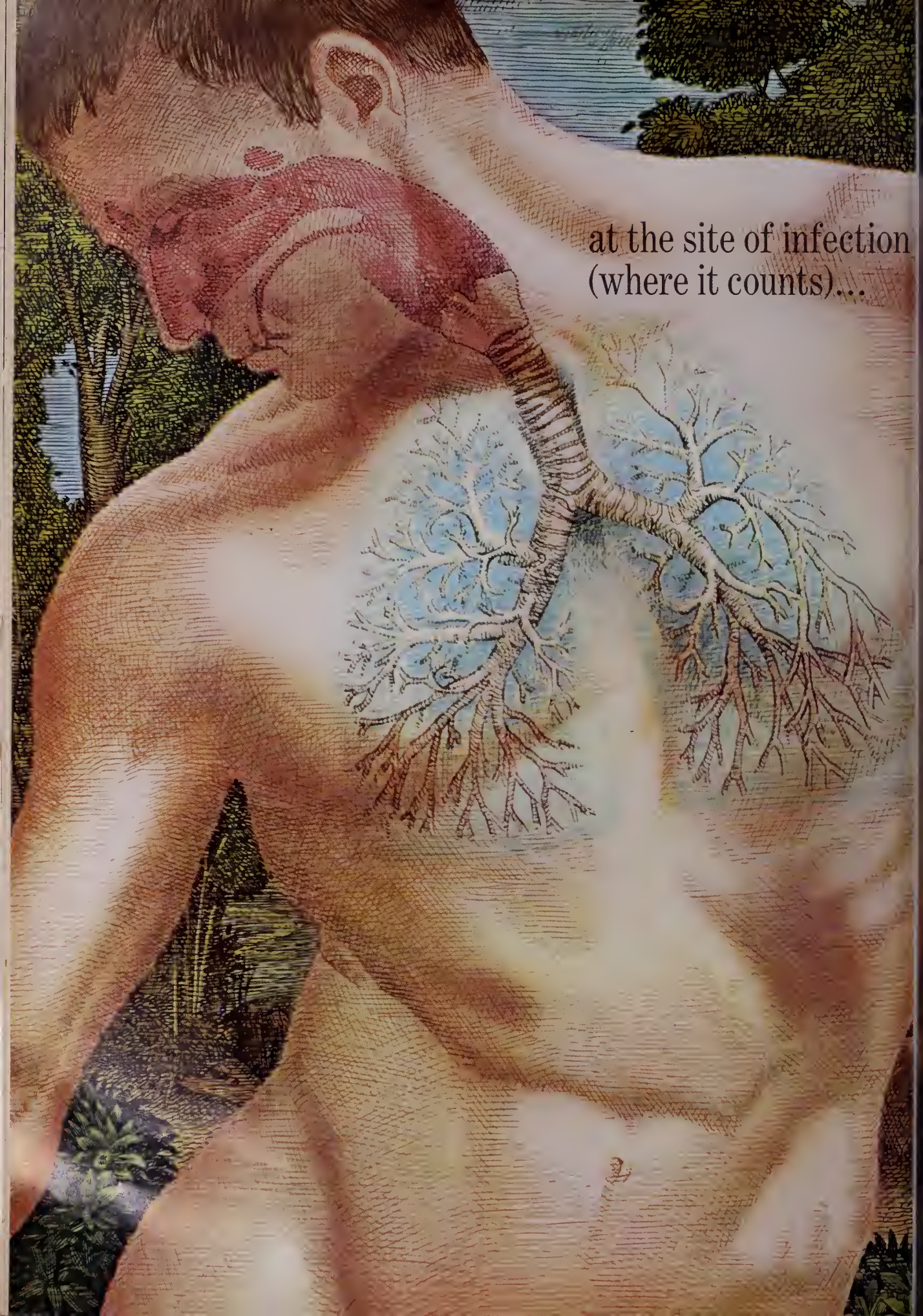
Dosage and Administration – In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications – Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution–Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects–Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appea be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive ce flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, an mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice h been reported in other patients taking prolonged courses medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six month patients with rheumatic fever have taken prophylactic do 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had ep of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mon rheumatic fever prophylaxis. The results were compare those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Ele of SGPT and serum alkaline phosphatase levels during the of treatment was observed in one patient treated with I and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the per group showed elevations in one of the tests at some time administration of the drugs.

Very satisfactory therapeutic results, without toxicity reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients comparable to those in a similar control group who had re penicillin.

Gastro-intestinal disturbances not associated with hepa fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative ba flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with t of erythromycin, there have been occasional reports of urt skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orall

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, fo Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds o weight, the usual dosage is 5 mg. per pound every six hou children twenty-five to fifty pounds, 125 mg. every six (Tablets Ilosone Chewable should be chewed or crushe swallowed with water.)

For adults and for children over fifty pounds, the usual of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythr therapy should be considered.

In the treatment of syphilis, the recommended total do 20 to 30 Gm. given in divided doses for a period of ten to days. Close follow-up of the patient is necessary since er mycin drugs have not had adequate evaluation in all sta syphilis. Examinations of spinal fluid are recommended a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four da recommended. In the treatment of gonorrhea, patients suspected lesion of syphilis should have a dark-field exami before receiving antibiotics, and monthly serologic tests be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 2 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equi to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pac

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equi to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pac

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-c packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:3
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Blue Shield Names Mr. McConnell To Succeed Mr. Tynes

D. Lane Tynes, Louisville, who has been serving as executive director of Kentucky Physicians Mutual, Inc. (Blue Shield), retired July 1. J. Ed McConnell, Louisville, assistant executive director of



Mr. Tynes



Mr. McConnell

Blue Shield, succeeds Mr. Tynes as president of the organization. Donald W. Giffin, Louisville, will serve as executive vice-president.

In order to be consistent with the organizational structure of the national Association of Blue Shield Plans and to parallel the organization of the local Blue Cross Hospital Plan, Inc., the board of directors of Blue Shield changed the format of their own organizational structure.

Under the new setup, the president of Blue Shield, Robert W. Robertson, M.D., Paducah, becomes chairman of the board. The office of executive director becomes the office of president; the office of assistant executive director becomes the office of executive vice-president and all other offices remain the same.

Under Mr. Tynes' administration, membership in Blue Cross has grown to more than one million, and Blue Shield membership is in excess of 931,000. Combined payments total more than $330 million. Mr. Tynes has been honored in the past for his work in establishing Blue Cross August 1, 1938, and Blue Shield August 1, 1949, by the Kentucky Medical Association's R. Haynes Barr Award and by the Kentucky Hospital Association's Distinguished Service Award.

Mr. McConnell, who graduated from Eastern Kentucky University in 1938, was employed by Blue Cross in 1942 and has served that organization as assistant director, vice president, and executive vice president. He is president of the Louisville Rotary Club and a past president of the Louisville Chamber of Commerce, Sales and Marketing Executives Council, St. Matthews Rotary Club and the Eastern University Alumni Association.

Two KMA Trustee Districts Hold Annual Meetings in May

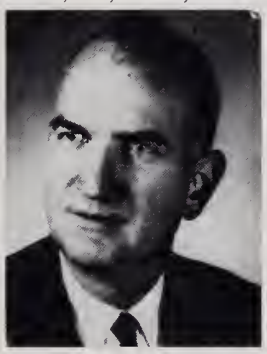
Robert E. Pennington, M.D., London, KMA president, was the featured speaker at the annual meetings of the Fourth Trustee District May 24 in Lebanon and the Seventh Trustee District May 25 in Frankfort.

Douglas David, M.D., Louisville, discussed "The Modern Concepts of Antibiotic Treatment of Respiratory Diseases" at the meeting of the Fourth District which was arranged by Henry S. Spalding, M.D., Bardstown, trustee. The Marion County Medical Society was host for the meeting.

Rudolf J. Noer, M.D., Louisville, spoke to the Seventh District on "Diverticular Diseases", and Fred C. Rainey, M.D., Elizabethtown, discussed the activities of KEMPAC. The meeting, arranged by Donald Chatham, M.D., Shelbyville, trustee, was held jointly with the Franklin County Medical Society.

College of Medicine Dean Named By UK Board of Trustees

The Board of Trustees of the University of Kentucky named William S. Jordan, Jr., M.D., Charlottesville, Va., dean of the College of Medicine June 2. The appointment will be effective September 1.



Doctor Jordan

Doctor Jordan succeeds William R. Willard, M.D., vice-president for the Medical Center, who served as dean of the College from the time of its establishment in July, 1956, until last September. Tom F. Whayne, M.D., assistant vice-president at the Medical Center, has been serving as acting dean since that time.

Doctor Jordan has been professor and chairman of the department of preventive medicine at the University of Virginia since 1958. He graduated from Harvard University Medical School in 1942 and completed his intern and residency training at Boston City Hospital.

The newly appointed dean is certified by both the American Board of Preventive Medicine and the American Board of Microbiology. His major research interest is the cause of acute respiratory infections, particularly the common cold.

Doctor Jordan has been appointed to a number of national committees and holds membership in 20 professional societies. He is the author of numerous publications, and he has been active in public health programs in Charlottesville. Doctor Jordan is an Episcopalian and has served as vestryman of St. Paul's Memorial Church in Charlottesville. He is married and the father of two children.

Virginia Wallace, M.D., will return to Irvine this fall to practice in the new Estill County Medical Clinic, according to a recent press report. Doctor Wallace had practiced in Irvine for 28 years before serving as health officer in Madison County for 18 months.

Wounds, abscess, cellulitis



...and the complications of staph.

From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

Bactericidal

Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo*, therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

Staph reliably controlled with specific therapy



1 suitable dosage form for every staph situation

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Whenever you suspect staph PROSTAPHLIN®

SODIUM OXACILLIN



Explore Kentucky Parks and all of Kentucky

...great for family vacations

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Capitol Annex Bldg., Frankfort, Ky. 40601

Please send, without obligation, information on Kentucky's parks and shrines.

Name_____

Address_____

City_____ State_____ Zip_____

Kentucky Surgical Society Elects Dr. Weddle; Dr. Dickinson

Richard H. Weddle, M.D., Somerset, who as vice-president of the Kentucky Surgical Society assumed the presidency to fill the vacancy created by the death of Charles M. Edelen, M.D., Louisville, in April, was elected president for a full-year term at the May 19-20 meeting of the Society at Park City.



Doctor Dickinson

John Dickinson, M.D., Glasgow, was named president-elect at the meeting, an office newly created by the Society. Doctor Dickinson was vice-president for the Western District of the Kentucky Medical Association in 1963-1964.

Blaine Lewis, M.D., Louisville, was re-elected secretary-treasurer and Delmas Clardy, M.D., Hopkinsville, was re-elected chairman of the Council. The Society plans to meet in Louisville next year.

Approximately 100 surgeons and their wives attended the session which featured two prominent Nashville surgeons on the scientific program. Barton McSwain, M.D., spoke on "Carcinoma of the Breast" May 19. Doctor McSwain is professor of surgery at the Vanderbilt University School of Medicine. Benjamin F. Byrd, Jr., M.D., who also holds a teaching position at Vanderbilt University School of Medicine, spoke on "The Role of Surgery in the Management of Thyrotoxicosis" May 20.

VA Hometown Program Outlined In Letter to Physicians

A new program to enable hometown physicians to treat certain military veterans was inaugurated on a national scale by the Veterans Administration recently. The program is explained in the following letter from Bernard N. Soderberg, M.D., Outpatient Service Chief at Veterans Administration, Louisville. Dear Doctor:

The Veterans Administration implemented a simplified procedure, beginning July 1, 1967, for authorizing each eligible veteran to obtain outpatient medical services from the physician of his choice. An Outpatient Medical Treatment Identification Card issued to the veteran will serve as his authority to obtain outpatient care. This procedure will substantially reduce paperwork associated with reporting and billing.

GENERAL. The veteran is entitled to outpatient treatment for any condition(s) recorded on his "I.D." card. Prior VA approval is not required unless fees for medical and ancillary services furnished and recommended by you exceed thirty dollars per month. Urgent treatment causing the fee limitation to be temporarily exceeded will be paid for on

(Continued on Page 704)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





In managing tense, anxious patients here's one combination that makes sense: your understanding counsel and **Serax**®

(oxazepam) Wyeth

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly (see Wyeth literature or PDR as well as "IN BRIEF" below).

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

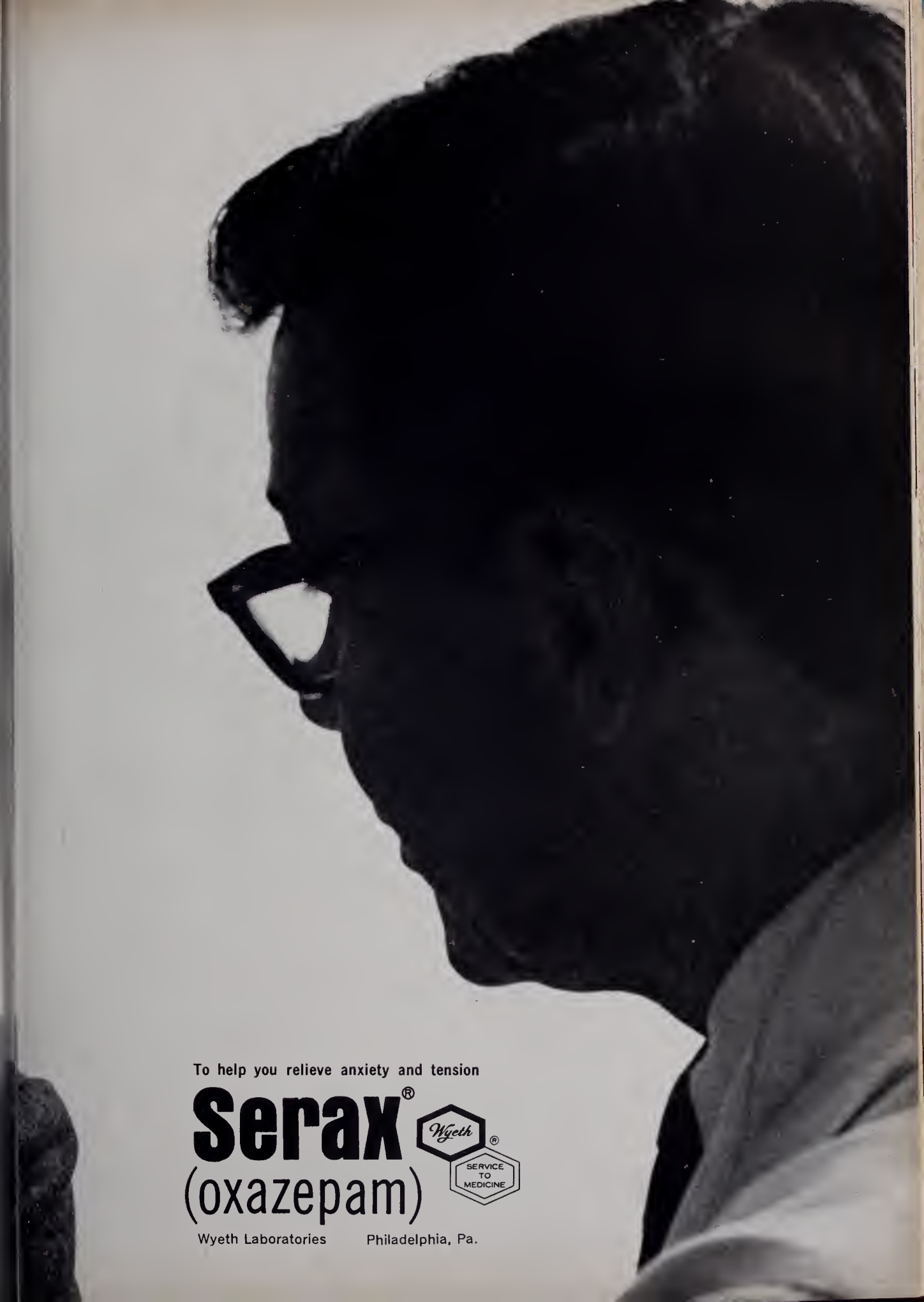
Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

Photograph posed by professional models.




To help you relieve anxiety and tension
Serax®
(oxazepam)
Wyeth®
SERVICE TO MEDICINE
Wyeth Laboratories Philadelphia, Pa.

(Continued from Page 700)

receipt of a brief report supporting the need for prompt medical attention.

BILLING. You may bill the VA (on your own stationery) for fees you normally charge to the general public. They will be paid to the extent that they do not exceed maximum rates established by a fee schedule negotiated with the State Medical Association. In the absence of a negotiated fee schedule, maximum rates will be established by the Veterans Administration. Payment will be expedited if the following are included on your itemized statement:

a. Patient's full name
b. His claim number
c. The service-connected condition(s) treated
d. The specific service(s) rendered and date(s)
e. Fee(s)

REPORTS. A treatment report is necessary only when the cost of urgent medical services temporarily exceeds the thirty dollar limitation or when the service-connected condition(s) has significantly changed. A change of condition may affect the veteran's benefits.

PRESCRIPTIONS. Prescriptions should be brought or mailed by the veteran to the VA Clinic of Jurisdiction when they are of a recurring nature or not needed at once. They will be filled promptly. When medication is needed immediately, it may be obtained from a private pharmacy by certifying on your prescription, "The VA has authorized me to treat the disability for which this prescription is written."

We appreciate your participation and cooperation in this program.

Dr. Harkess to be First Occupant Of Kosair Chair at U of L

James W. Harkess, M.D., professor of surgery at the Medical College of Georgia, Augusta, and assistant chief of orthopedics at Eugene Talmadge Memorial Hospital, has been named first occupant of the newly established Kosair chair of orthopedic surgery in the University of Louisville School of Medicine.



Doctor Harkess

Equal funds donated by Kosair Hospital and the University of Louisville will be used to provide assistants and research facilities for Doctor Harkess. Clinical research will be an important part of his work.

Doctor Harkess, a native of Scotland, graduated from the University of Edinburgh in 1948. He was practiced in Scotland, England, and Albany, New York. He is a member of the American Academy of Orthopedic Surgeons, the Association of Bone and Joint Surgeons, and the Georgia Orthopedic Society.

Tandearil®
oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again



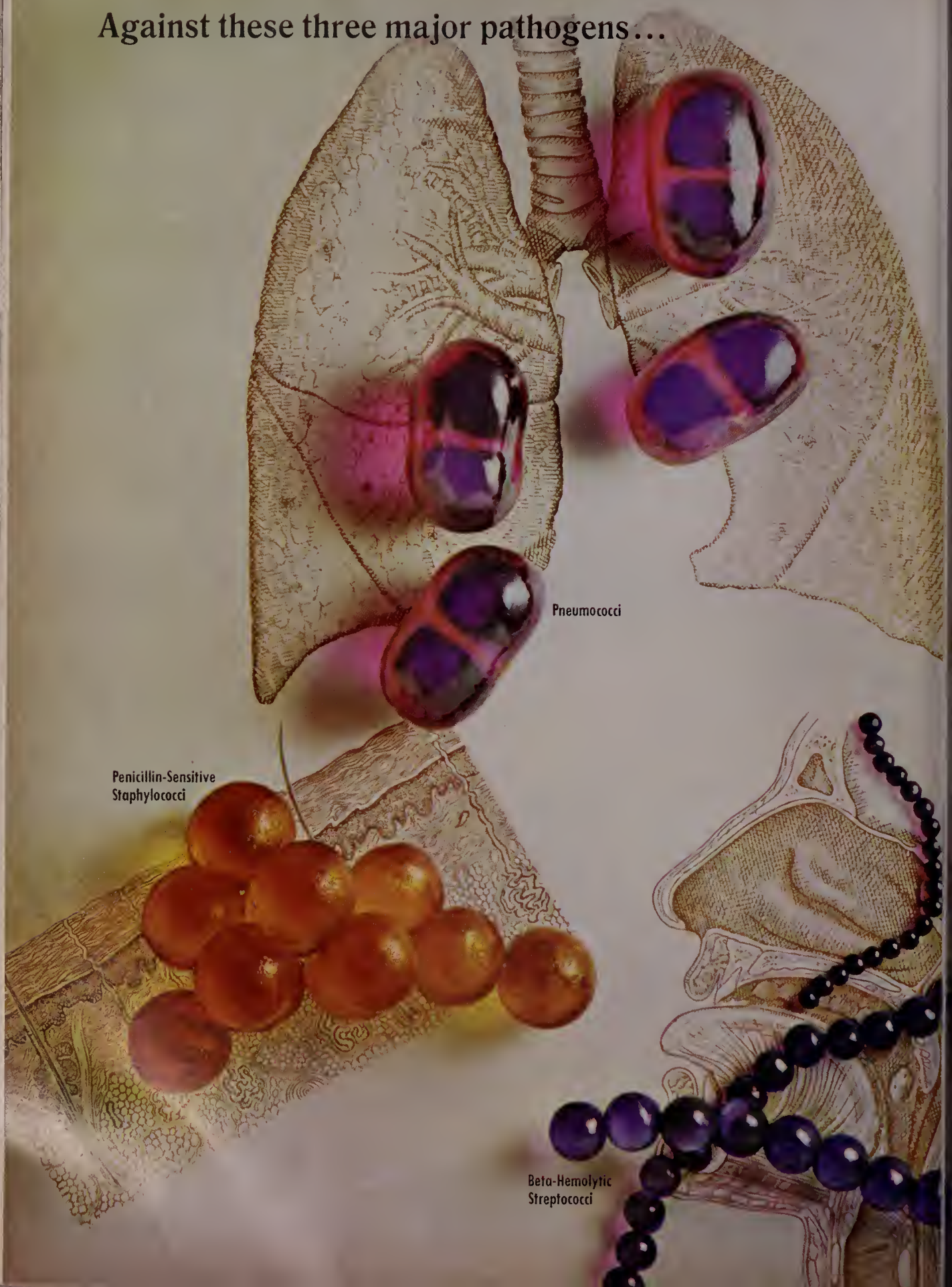
3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary

TA-4919 PC

Against these three major pathogens…



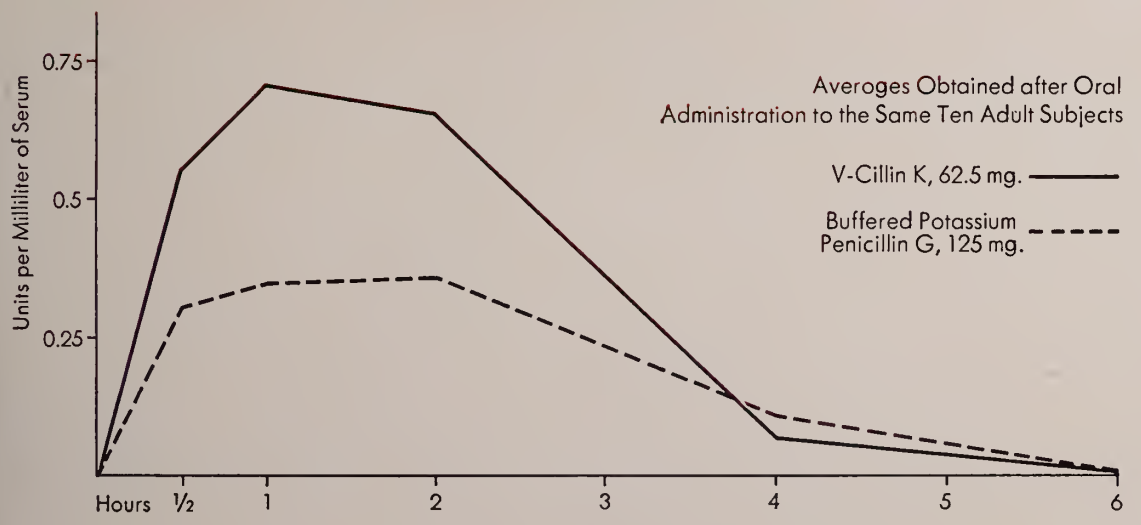
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Stoph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxocillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

V-Cillin K® Lilly 700636

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory st (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrow pencillin-insensitive organisms. In such cases, its administration sl be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are mucl common with administration of oral penicillin than with intramus forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a si cant index of sensitization. The following hypersensitivity reac associated with the use of penicillin have been reported: skin r ranging from maculopapular eruptions to exfoliative dermatitis; caria; and reactions resembling serum sickness, including chills, f edema, arthralgia, and prostration. Severe and often fatal anaphy has occurred (see Warnings). Hemolytic anemia, leukopenia, t bocytopenia, and nephropathy are rarely observed side-effects are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cil Pediatric, the usual dosage ranges from 125 mg. (200,000 units) times a day to 500 mg. (800,000 units) every four hours. For inf the daily dosage may be 50 mg. per Kg. of body weight divided three doses.

Beta-hemolytic streptococcus infections without associated teremia may be treated with 200,000 to 400,0000 units three tim day. Therapy should be continued for a minimum of ten days to pr development of rheumatic fever and/or other serious complicat Dosage for routine streptococcus prophylaxis in patients with a hi of rheumatic fever or congenital heart disease may be 200,000 once or twice daily. When such patients undergo tonsillectomy, extraction, or other minor surgery, the prophylactic dose shoul 500,000 units every six hours given two days prior to surgery an two days postoperatively. If oral medication is not feasible on the of surgery, parenteral therapy should be considered. Mild to m ately severe pneumococcus pneumonia has been treated effec with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be g every six to eight hours in conjunction with indicated surgical p dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hou three doses may be employed; in females, 500 mg. every four h for six doses are recommended. Refractory infections generally res to a second treatment three to four days following completion o first. Treatment of gonorrhea with severe complications shoul individualized, with prolonged and intensive treatment. Patients w suspected lesion of syphilis should have a dark-field examinatio fore receiving penicillin and monthly serologic tests for a minimu three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 (800,000 units), in bottles of 24 and 100.

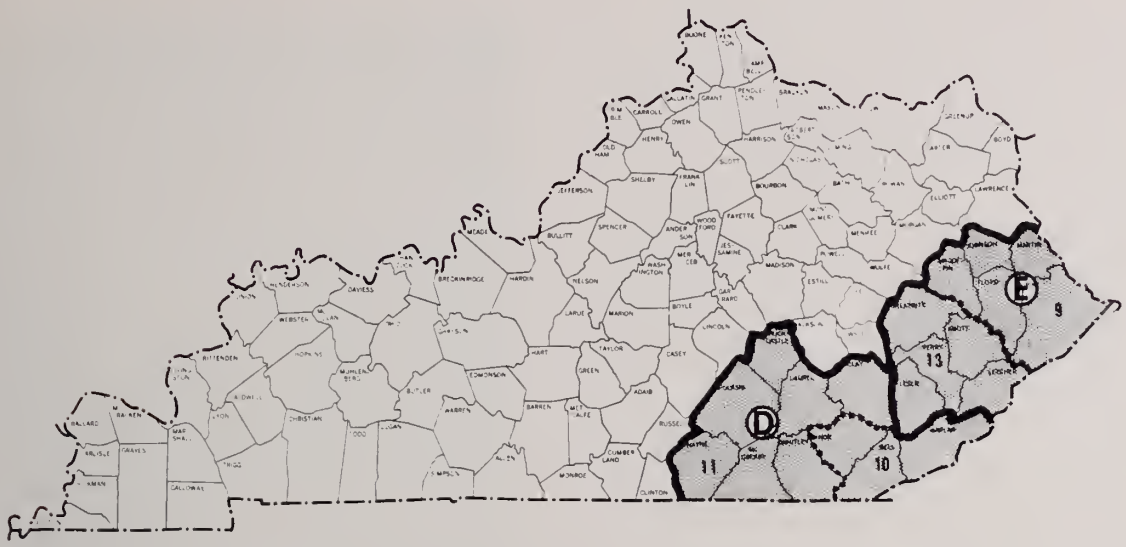
V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [03

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

7

Kentucky-Cornell Automotive Crash Injury Research



The second six month phase of the current three-year Kentucky-Cornell Automotive Crash Injury Research project will be conducted in the darker areas shown on the above map. The second sampling period began on July 1 and will end December 31, 1967.

Auto Safety Program Begins Phase Two of 3-Year Study

Phase two of the second three-year research study aimed at making automobiles safer began July 1 in Kentucky. The nature and specific causes of injury to occupants of recent model passenger cars involved in rural accidents are the primary considerations in the current study.

The program is sponsored by KMA, Kentucky State Department of Health, Kenutcky Hospital Association and the Kentucky State Police in cooperation with Cornell University. The second six month phase of the program will take place in Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Leslie, Letcher, Magoffin, Martin, McCreary, Perry, Pike, Pulaski, Rockcastle, Wayne and Whitley Countries (See map above.)

If you are a physician in one of these counties, you may be asked to participate in this Automotive Crash Injury Research data collecting project. Whenever an occupant of a passenger car of the last five year model is injured or killed, a State Police Officer will provide you with a special medical report form to record specific information on injuries.

William Keller, M.D., Louisville, KMA Highway Safety Committee Chairman, urges your cooperation in this effort to reduce deaths and injuries in future auto accidents.

F. A. Martin, Jr., M.D., recently opened an office in Danville for the practice of urology. Doctor Martin graduated from Manila Central University Medical School in 1956 and has practiced in Pikeville and Paris.

Problems of Emergency Room Care Discussed at June Conference

William T. Rumage, Jr., M.D., Louisville, chairman of the KMA Disaster Medical Care Committee, expressed pleasure at the high attendance recorded at the Hospital Emergency Room Conference June 10 in Louisville. Doctor Rumage was moderator for the program. Approximately 85 physicians, nurses, administrators representing some 28 hospitals and Blue Cross-Blue Shield representatives attended the conference.

Richard E. Manegold, M.D., Chicago, director of the department of hospitals and medical facilities of the AMA, presented a general picture of emergency room facilities and cases on a nationwide basis.

Spencer T. Snedecor, M.D., Hackensack, N.J., chairman of the Emergency Room Standards Subcommittee of the American College of Surgeons' Committee on Trauma, discussed "Quality Patient Care." Doctor Snedecor outlined the requirements necessary for good emergency room care to give his audience a basis for comparison with facilities in their own hospitals and communities.

The afternoon session, devoted to panel discussions of various emergency room procedures used in Kentucky hospitals, included descriptions of the King's Daughters Hospital resuscitation program in Frankfort and techniques implemented in Henderson, Ashland and Lexington. KMA, the Kentucky Hospital Association, and the Trauma Committee of the Kentucky Chapter of the American College of Surgeons co-sponsored the one-day conference.

Student American Medical Assoc. Holds Annual Convention

Talks by distinguished physicians and a meeting of the House of Delegates were features of the 17th annual convention of the Student American Medical Association in Chicago May 3-6, according to Frank Rickman, delegate from the University of Louisville School of Medicine.

"Sexual Problems and the Physician's Responsibility" was the title of a discussion by William H. Masters, M.D., director of the Reproductive Biology Research Foundation in St. Louis; Mary S. Calderone, M.D., executive director of the national Sex Information and Education Council; and Edward M. Litin, M.D., chairman of the Mayo Clinic's department of psychiatry.

Duke D. Fisher, M.D., and Thomas J. Ungerleider, M.D., both from the UCLA Neuropsychiatric Institute, conducted a symposium on "Hallucenogenic Drugs and Their Psychiatric Implications." Walter C. Alvarez, M.D., chief of the Public Health Service's Division of Medical Care Administration, also appeared on the program.

Topics discussed and acted upon by the House of Delegates, according to Rickman, included therapeutic abortions, military medical matters, house staff salaries, student participation in curriculum planning, the AMA-ERF loan fund, development of foreign preceptorship programs, prescription of drugs, community activities in deprived areas, and cooperative activities with other medical groups.

Seventeen Physicians Added To KMA Membership

Seventeen physicians have joined the Kentucky Medical Association according to the records of the membership department as of June 20.

New members in Lexington are John R. Curtis, M.D., Paul G. Kyker, Jr., M.D., John E. Trevey, M.D., and Jack H. Welch, M.D. New members in Henderson are Sohrab Amini, M.D., John Barrow, M.D., M.G. Howell, M.D., and Wayne C. Liles, M.D.

The other new members are Albert G. Izquierdo, M.D., and Milo R. V. Paradis, M.D., both of Covington; William N. Blalock, M.D., Paducah; Amalia A. Hickman, M.D., Cold Spring; Jack B. Holt, M.D., Russellville; William Klompus, M.D., Madisonville; Harold K. Mines, M.D., Cadiz; George A. Renaker, M.D., Erlanger; and Paul L. Tagher, M.D., Florence.

Mr. Connelly Named To KHA Staff

The Kentucky Hospital Association has named Thomas F. Connelly, Jr., Durham, N.C., assistant to Hasty W. Riddle, Louisville, executive vice president. Mr. Connelly, who received a master of hospital administration degree from Duke University in June, has been administrative resident at Moses H. Cone Memorial Hospital in Greensboro, N.C.



Take five...

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. LABSTIX is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with LABSTIX are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with LABSTIX may help in detecting hidden pathology before marked symptoms are manifest.

*Blood; ketones; glucose; protein, and pH.

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...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. "Negatives" may help rule out suspected abnormalities over a broad clinical range and are important for the patient's record.

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In Memoriam

CLIFFORD N. HEISEL, M.D.
Covington
1889-1967

Clifford N. Heisel, M.D., 77, a Covington physician, died May 27 at St. Elizabeth Hospital where he had been a patient for several weeks. Doctor Heisel graduated from the University of Cincinnati College of Medicine in 1912 and had practiced in Covington since 1929. He was honored by fellow physicians in 1964 in recognition of 50 years of practice.

OSCAR L. MAY, M.D.
Danville
1883-1967

Oscar L. May, M.D., 84, a Danville surgeon for more than 50 years, died June 6 at Friendship House Nursing Home. Doctor May graduated from the University of Louisville Medical School in 1907 and was a member of the original medical staff of Ephraim McDowell Memorial Hospital.

HERSHELL B. MURRAY, M.D.
West Liberty
1907-1967

Hershell B. Murray, M.D., 59, a West Liberty physician, died May 21 in a boating accident on the Kentucky River near Lexington. Doctor Murray graduated from the University of Louisville School of Medicine in 1932. He was a member of the American Academy of General Practice and secretary of the University of Kentucky Board of Trustees.

SYRE L. POLK, M.D.
Paducah
1895-1967

Syre L. Polk, M.D., 72, a Paducah physician, died March 7 at Lourdes Hospital. Doctor Polk graduated from Meharry Medical College in Nashville in 1925.

Mr. Giffin Receives JCMS Award

The Jefferson County Medical Society presented its Lay Award of Merit to Donald W. Giffin, Louisville, executive vice-president of Blue Cross-Blue Shield, at the Society's annual meeting May 15. The Award, given for an outstanding contribution to medical care in Jefferson County, was presented to Mr. Giffin by W. Fielding Rubel, M.D.,

Doctor Rubel said that Mr. Giffin was chosen as this year's Award recipient for the special service he has rendered as chairman of the City-County Board of Health since 1965.

Orientation Program Attendants Since 1965 Listed By KMA

The KMA Orientation Program, approved in a bylaw amendment by the House of Delegates in September, 1964, has now resulted in four Orientation Courses being presented for new KMA members.

N. Lewis Bosworth, M.D., Chairman of the Council on Communications and Public Service, recently reported that 183 new members have taken the course since its inception two years ago. An Orientation Program is held at least twice annually, in conjunction with the Interim Meeting and the Annual Meeting.

Listed below are the names of those physicians who have completed the course to date along with the particular program attended. Anyone who has been present for one of these sessions and does not find his name listed should contact the KMA Headquarters office.

KMA Annual Meeting, Louisville

September 20, 1965

L. Charles Allen, M.D., Lexington; Cesar Arcangel, M.D., Louisville; Emmanuel Avlonitis, M.D., Louisville; J. Hunter Black, M.D., Morehead; David Lorenz Brown, M.D., Lexington; Henry C. Cassini, M.D., Louisville; Robert B. Chambliss, M.D., Burkesville; Roy L. Clemons, M.D., Louisa; James R. Collins, M.D., Lexington; Ruth Coppedge, M.D., Hopkinsville; Kenneth R. Crabtree, M.D., Gamaliel; Howard Dehaven, M.D., Louisville; Francis J. Dillard, M.D., Mayfield; Cleto Elequin, Jr., M.D., Lexington; Brian P. Geoghegan, M.D., Lexington; John F. Gilbert, M.D., Lawrenceburg; Raul C. Gonzalez, M.D., Louisville; Airzzie W. Greene, M.D., Franklin; Booker T. Holmes, M.D., Frankfort; Glenn Scoble Hooper, M.D., Lexington; Carroll E. Howard, M.D., Owensboro; Robert M. Izard, M.D., Louisville; Henry A. Jones, M.D., Flatwoods; Robert .T Johnson, M.D., Beaver Dam; Donald J. Kaderabek, M.D., Elizabethtown; Robert J. Kaiser, M.D., Louisville; James F. Kurfees, M.D., Crestwood; Juan R. Lacerda, M.D., Fort Thomas; James M. Lee, M.D., Louisville; Thomas E. Lester, M.D., Lynch; James E. McAfee, M.D., Horse Cave; John A. McKay, Jr., M.D., Owensboro; Jerry W. Martin, M.D., Bowling Green; Gaston Maya, M.D., Louisville; Terrell Mays, M.D., Louisville; Kareem Minhas, M.D., Louisville; D. H. Morrow, M.D., Lexington; Leonidas Mostowycz, M.D., Lexington; Frank W. Oliphant, M.D., Cadiz; Harvey Page, M.D., Pikeville; William E. Pearson, Jr., M.D., Owensboro; Bernhardt L. Pederson, M.D., Lexington; Thomas F. Plaut, M.D., Whitesburg; Herman D. Pocock, M.D., Louisville; Alvin D. Poweleit, M.D., Covington; Thomas D. Pruitt, Jr., M.D., Harlan; Robert E. Robbins, M.D., Greenville; John W. Roddick, Jr., M.D., Lexington; Jo Anne Sexton, M.D., Frankfort; Philip Van Deventer, M.D., Hopkinsville; Paul M. Walstad, M.D., Har-

(Continued on Page 714)

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LOUISVILLE'S MEDICAL CENTER

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FLOYD and GRAY STREETS

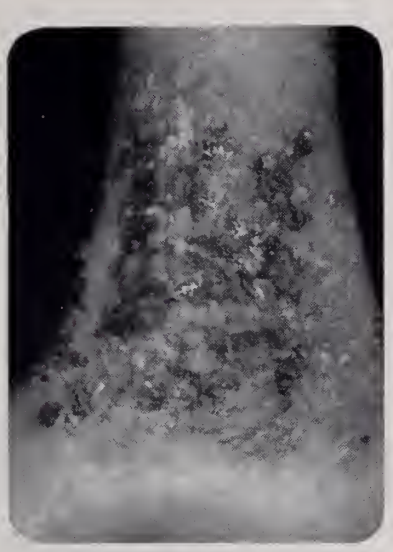
A NEW SERVICE FOR YOUR PATIENTS AND THEIR FAMILIES

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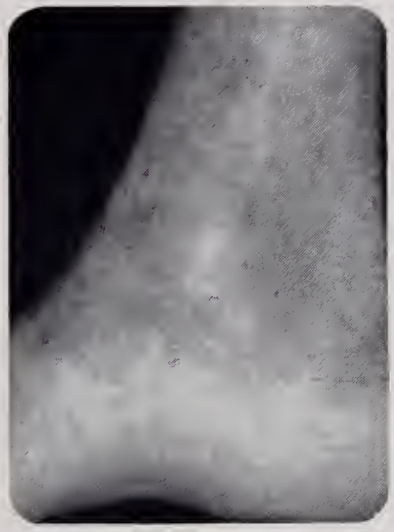
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(Continued from Page 712)

lan; Gerald A. Weigel, M.D., Somerset; Arthur F. White, M.D., Louisville; John D. Winebrenner, M.D., Louisville; Ardy C. Wright, M.D., Cadiz; William R. Yates, M.D., Bloomfield.

Guests

D. J. Aderabek, M.D.; Keene M. Hill, Jr., M.D.; Stephen B. Kelley, M.D.; Juan R. Laurder, M.D.; C. C. Lowry, M.D.; Mr. William Samuels; Angelo A. Speno, M.D.

KMA Interim Meeting, Cumberland Falls

April 13, 1966

John D. Ammon, M.D., Hebron; Bennett Asher, M.D., Winchester; Glenn F. Baird, M.D., Florence; F. Calvin Bigler, M.D., Morehead; George C. Cheatham, Greensburg; Charles J. Corea, M.D., Lynch; James S. Cox, M.D., Hopkinsville; John E. Engle, M.D., Whitesburg; John W. Ford, M.D., Inez; Patrick Galla, M.D., Louisville; Larry L. Hall, M.D., Mayfield; Van R. Jenkins, M.D., Carlisle; Alan G. Johnson, M.D., Madisonville; Frank W. Lehn, M.D., Louisville; Don C. McFadden, M.D., Mt. Sterling; Fitzhugh Mullins, M.D., Louisville; Charles H. Nicholson, M.D., Lexington; Arvis Porter, M.D., Morehead; Bernard O. Rand, M.D., Lexington; Lloyd F. Redick, M.D., Lexington; Charles D. Scarborough, M.D., Murray; Robert P. Simmons, M.D., Greensburg; Orville J. Stein, M.D., Somerset; Michael D. Thomas, M.D., Somerset; John J. Wernert, Jr., M.D., Louisville; E. David Weinstein, M.D., Lexington; Carl E. Yaple, M.D., Harlan; Ahmet H. Yilmaz, M.D., Louisville.

KMA Annual Meeting, Louisville

September 19, 1966

Jose Amorocho, M.D., Louisville; James E. Anderson, M.D., Owensboro; S. Taha Anvari, M.D., Louisville; Mohammed Atik, M.D., Louisville; Barbara Bates, M.D., Lexington; R. L. Beanblossom, M.D., Louisville; Wm. B. R. Beasley, M.D., Hyden; Walter F. Beckett, M.D., Bowling Green; Arnold M. Belker, M.D., Louisville; Joe D. Bernard, M.D., Lexington; George F. Berry, M.D., Lancaster; M. C. Blaydes, M.D., Lexington; Thomas D. Brower, M.D., Lexington; Vernon Bundy, M.D., Louisville; Earl L. Carpenter, M.D. Lynch; Wm. D. Caso, M.D., Louisville; Wm. B. Cook, M.D., Prestonsburg; Arthur Daus, M.D., Louisville; Wm. C. Edwards, M.D., Louisville; E. Kathie Elliott, M.D., Louisville; Stuart A. Fink, M.D., Louisville; Harry Galloway, M.D., Paris; Dorothy Gates, M.D., Berea; Lyndon S. Goode, M.D., Hopkinsville; Ward O. Griffen, M.D., Lexington; Doyle D. Hagg, M.D., Frankfort; Harold Haller, M.D., Louisville; Jan D. Hasbrouck, M.D., Lexington; Ahmed Hatam, M.D., Louisville; C. E. Hernandez, M.D., Frankfort; Gary Hogge, M.D., Louisville; D. V. Hollingsworth, M.D., Georgetown; Thomas Hutsell, M.D., Louisville; Ronald Kaplan, M.D., Louisville; Maxwell Kimball, M.D., Lexington; Donald Kmetz, M.D., Louisville; F. A. Martin, M.D., Paris; James A. Meyers, M.D., Louisville; G. Dudley

Nelson, M.D., Louisville; O. M. Patrick, M.D., Frankfort; Luther W. Pearce, M.D., Louisville; Francis J. Peisel, M.D., Louisville; Michael Peveler, M.D., Louisville; James F. Rice, M.D., Louisville; Roger D. Salot, M.D., Louisville; Richard B. Salsitz, M.D., Louisville; Okey Sanford, Jr., M.D., Ashland; Robert O. Schoffstall, M.D., Whitesburg; Sheldon B. Schiller, M.D., Louisville; David Wright Scott, M.D., Lexington; Menefee Seay, M.D., Louisville; Mark S. Sexter, M.D., Louisville; Robert G. Spurling, M.D., Louisville; James P. Sutherland, M.D., Louisville; John Urton, M.D., Louisville; Harry Voyles, M.D., Louisville; Kenneth N. Walton, M.D., Lexington; Richard T. C. Wan, M.D., Morgantown; Keene A. Watson, M.D., Lexington; Sidney W. Winchell, M.D., Louisville; Walter M. Wolfe, M.D., Louisville;; Walter F. Yates, M.D., Lexington.

KMA Interim Meeting, Gilbertsville

April 19, 1967

Ruby Arnsparger, M.D., Louisville; W. E. Badenhausen, Jr., M.D., Louisville; Curtis Bippert, M.D., Paducah; John P. Blackburn, M.D., Bowling Green; R. K. Brown, M.D., Georgetown; B. Cymbala, M.D., Henderson; Keith E. Ellis, M.D., Benton; Lowell E. Ford, M.D., Covington; Howard Heringer, Jr., M.D., Covington; Charles E. Howard, M.D., Mayfield; Hilary L. Hunt, M.D., Mayfield; Robert H. Hyde, M.D., Eddyville; Harold L. Johnson, M.D., Frankfort; Nicholas Z. Kafoglis, M.D., Bowling Green; Clifton D. Lamm, M.D., Smiths' Grove; Robert J. Long, M.D., Berea; Dan A. Martin, M.D., Madisonville; Edward Martin, M.D., Frankfort; Keith Martin, M.D., Ashland; Lewis Martin, M.D., Adairville; Charles W. Mercer, M.D., Murray; Joseph L. Milburn, M.D., Madisonville; Charles Noss, M.D., Stanton; Robert R. O'Connor, M.D., Louisville; Frank R. Pitzer, M.D., Hopkinsville; Glen D. Richards, M.D., Lewisport; William Rogers, M.D., Madisonville; Philip R. Rothrock, M.D., Danville; Nelson B. Rue, M.D., Bowling Green; John Sanders, M.D., Owensboro; Marilyn Sanders, M.D., Owensboro; William P. Stone, M.D., Bowling Green; Frank T. Varney, M.D., Stone; A. V. Wilwayco, M.D., Franklin.

Retires As AAMSE President

J. P. Sanford, KMA executive secretary, completed his term as president of the American Association of Medical Society Executives at the organization's 21st Annual Dinner Meeting in Atlantic City, June 17. He was succeeded by John Hart, Chicago, executive secretary of the American Society of Orthopedic Surgeons.

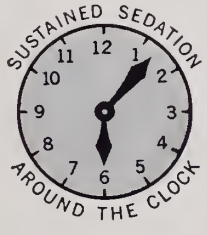
The AAMSE is composed of approximately 400 members of staff people who work for medical organizations at county, state, regional and national levels. Emphasis during the past year was placed on providing more continuing educational opportunities for the AAMSE members.

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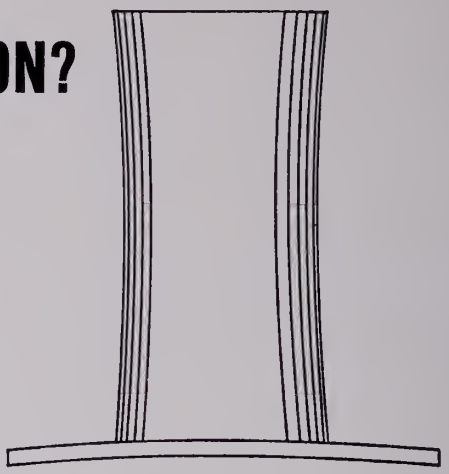
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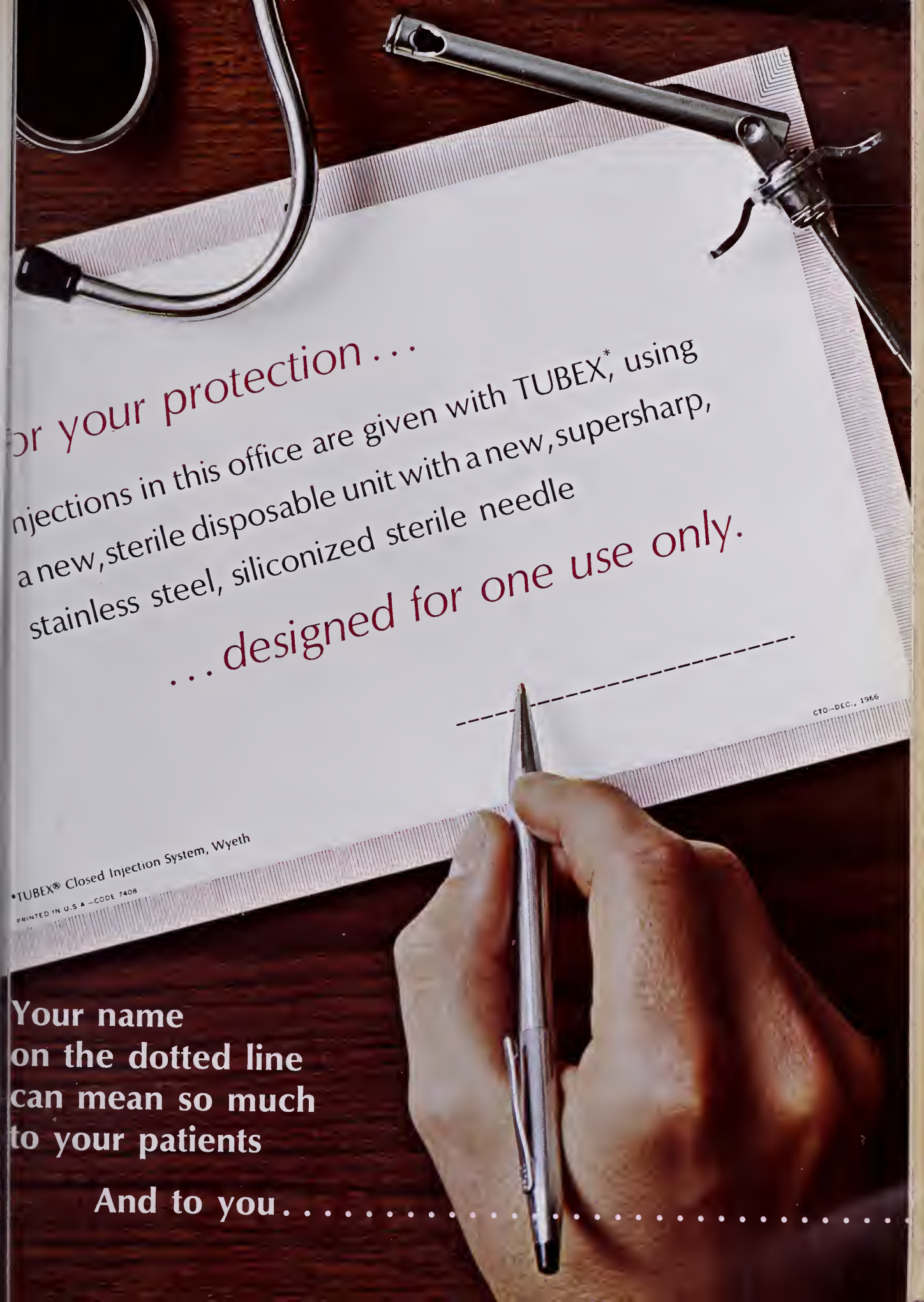
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KMA Council and Committee Reports

Committee on Medicine and Religion

R. Burke Casper, M. D., Louisville, Chairman

KMA Headquarters Office **May 3, 1967**

The Committee was pleased to have as its guests during its second meeting of this associational year, both the KMA District Medicine and Religion Chairman and six church pastors and hospital chaplains.

Coordination between the professions of medicine and clergy was a prime consideration of those in attendance. In addition, the Committee reviewed the film entitled "The One Who Heads" and made plans for the Annual Breakfast during the KMA Annual Meeting in September.

Physical Medicine and Rehabilitation Committee

William K. Massie, M.D., Lexington, Chairman

KMA Headquarters Office **May 4, 1967**

This committee is continuing an indepth study of Kentucky's Workmen's Compensation Law and the latest meeting followed coordination of efforts with the state's Commissioner of Labor.

The law was reviewed by section, with discussion in detail of those portions the committee members thought needed revision from a medical viewpoint. Aiding in the discussion was a representative of the University of Kentucky Medical Center's Bureau of Rehabilitation Services.

General Practice Committee

Charles B. Spalding, M.D., Bardstown, Chairman

Kentuckiana Room **May 11, 1967**
Sheraton Hotel
Louisville

As is customary for this committee, a meeting was held during the Annual Assembly of the Kentucky Academy of General Practice.

This committee has supported and continues to support through a well defined educational program the encouragement of the training of more and better qualified physicians who will pursue family or general practice, and this subject was the major consideration at the meeting.

Other discussion items included programs relating to general practice at medical schools, educational television, and the physician's office as a center for comprehensive medical care.

Louise Hutchins, M.D., Berea, was among 10 Kentucky women honored by the Kentucky Federation of Business and Professional Women's Clubs at a luncheon May 13 at Spindletop Hall. Doctor Hutchins was nominated for her part in establishing the Mountain Maternal Health League.

Allergic Reactions to Insect Stings

(Continued from Page 671)

The differential diagnosis of various types of insect stings has been discussed.

The prevention of stings by the use of appropriate clothing, abstinence from cosmetics and proper methods of avoidance has been discussed.

Hyposensitization is clearly of benefit and lessens the intensity of the reactions in 90% of the cases. It should be carried up to the highest tolerated dose. This should be continued for an indefinite period and should consist of the venom and whole body extract of bee, wasp, yellow jacket and hornet. Protection may be maintained for years or may be lost in less than a year following discontinuation of hyposensitization, but progressively severe reactions to stings are uncommon following recent adequate hyposensitization.

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COUNTY SOCIETY REPORTS

McCracken

The regular monthly meeting of the McCracken County Medical Society was held May 24 at Boswell's Restaurant in Paducah. John Burch, M.D., Nashville, presented a program on "Bleeding in Women" and "Stress Incontinence and Its Management."

The proposed "Pap" smear program, which had been discussed by the Society at previous meetings, was approved. The Society also decided that plans for the program should be made during the summer by the Public Health Advisory Committee.

The Society approved a Home Nursing Service which will be responsible to the County Health Office and used when ordered by local physicians. The program will include nursing, physiotherapy and other services.

Four new members were accepted into the Society. They are Wally O. Montgomery, M.D., Frank E. Reeder, M.D., Marlow Harston, M.D., and William Blalock, M.D.


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Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.[6] (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

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Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.



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Heart Assoc. Elects Dr. Pedigo

The Kentucky Heart Association elected George W. Pedigo, Jr., M.D., Louisville, president at its 18th annual meeting June 7 at the Brown Hotel, Louisville. Doctor Pedigo succeeds Walter S. Coe, M.D., also of Louisville.

John S. Llewllyn, M.D., Louisville, and Roy J. Moser, M.D., South Fort Mitchell, were elected vice presidents. Willard C. Butcher, New York City, senior vice president of the Chase Manhattan Bank, gave the luncheon meeting address.

Measles Vaccination Study

(Continued from Page 677)

home visits (*no-response group*) results were: 22.5% not able to locate, 41.1% unprotected, and 37.2% protected.

5. Parents' statements regarding immunization were verified by their physicians' records. When the parent stated the child had *not* had measles vaccine, they were 93% correct but when the parent stated the child *had* had the vaccine, they were only 80% correct.

Letter Sent to Experimental Group

Hopkins County Health Department
Madisonville, Kentucky
May 20, 1966

Dear Parent:

From the minute a baby is born, he begins counting on you to keep him safe . . . warm . . . happy. He's counting on you to protect him from the serious diseases most children get. Don't let him down, *protect him against measles*. Children are unprotected against measles unless immunized. You are his only defense, so see that he gets the protection he needs.

Five Facts About Measles

(Sometimes called "9 day" measles; red measles; old fashioned measles)

(1) Measles still kills children and can cause serious disease such as encephalitis, pneumonia, and chronic ear problems.

(2) Almost 19,000 Kentucky children had measles in 1964.

(3) Hopkins County has had 154 cases reported so far this year; many more probably were not reported.

(4) *A vaccine to prevent measles is now available.*

(5) The vaccine is usually given about one year of age.

Help stamp out this disease as we did with polio; have your child vaccinated against this condition. See your family doctor or check with your health department as soon as possible. The Hopkins County Health Department telephone number is 821-5242.

Hopkins County Health Department
Madisonville, Kentucky

Special Article

(Continued from Page 682)

patient diagnostic X-ray and lab, and, in short, medicine as we know it in contrast to the highly restricted panel system!

Conclusion

Here then are some of the reasons why I support my Blue Shield Plan and think that you should: Blue Shield is respected nation wide, especially by our legislators. We still cover health care costs for 58 million Americans and are meeting the daily challenge to make these programs even better and more effective. We expect Blue Shield to counsel and lead in the development of new programs, not just blindly follow the dictates of either the market or the profession!

Always in the background of Blue Shield thinking is the theme that the traditional voluntary prepayment mechanism is the best from the standpoint of economics, patient care, doctor-patient relationship, and doctor co-operation.

We have taken a look back and a look ahead. We have attended session after session devoted to "Who Cares for People," "Conservation of the Health Care Dollar", "What Labor Wants," "What Management Wants." Someone asked the question "Who Cares for Doctors?"

Blue Shield has cared for doctors and protected them as no one else could! As we take a look ahead it will still be Blue Shield, our economic arm in which we have the large measure of control, provided we see that it leads from the strength of our support. This is the strength that the representatives of the people understand.

NEWS ITEMS

J. Leland Tanner, M.D., closed his office in Henderson May 15. Doctor Tanner was recently honored by the Henderson County Medical Society at its centennial celebration for his contribution to medicine there.

Fred V. Echiverri, M.D., recently opened an office in the Bourbon Medical Center, Paris, limiting his practice to general surgery. Doctor Echiverri graduated from the University of St. Thomas, Manila, in 1957.

Hobart D. Belknap, M.D., recently resigned as director of the emergency section of Louisville General Hospital. Doctor Belknap has served as director for 10 years.

County Med. Society Officers Named for 1967

The Kentucky Medical Association received the names of the following County Medical Society officers for 1967 as of June 20:

Anderson

President: B. J. Jackson, M.D., Lawrenceburg
Secretary: Boyd Caudill, M.D., Lawrenceburg
Delegate to KMA: Boyd Caudill, M.D.
Alternate: B. J. Jackson, M.D.

Breckinridge

President: James Sills, M.D., Hardinsburg
President-Elect: Harold W. Owens, M.D., Irvington
Vice-President: Harold W. Owens, M.D.
Secretary-Treasurer: William D. Hatfield, M.D., Irvington
Delegate to KMA: James Sills, M.D.
Alternate: Carroll James, M.D., Hardinsburg

Campbell-Kenton

President: Donald Janney, M.D., Covington
President-Elect: Robert Heimbrock, M.D., Erlanger
Vice-President: Carl Brueggemann, M.D., Covington
Secretary-Treasurer: C. C. Hugan, Jr., M.D., Covington
Delegates to KMA: Thomas L. Heavern, M.D., Highland Heights
Paul H. Klingenberg, M.D., Covington
Robert Longshore, M.D., Covington
C. J. Brueggemann, M.D.
Donald K. Dudderar, M.D., Newport
W. V. Pierce, M.D., Covington

Carlisle

President: Thomas T. Brackin, M.D., Bardwell
Secretary-Treasurer: John O'Neil, M.D., Arlington
Delegate to KMA: John O'Neil, M.D.
Alternate: Thomas T. Brackin, M.D.

Christian

President: Raymond Snowden, M.D., Hopkinsville
Vice-President: Harvey Stone, M.D., Hopkinsville
Secretary-Treasurer: Edwin R. Davis, M.D., Hopkinsville
Delegates to KMA: W. Faxon Payne, M.D., Hopkinsville
Norma T. Shepherd, M.D., Hopkinsville
Alternates: Robert Coleman, M.D., Hopkinsville
Preston T. Higgins, M.D., Hopkinsville

Clark

President: Robert L. Davis, M.D., Winchester
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Pulmonary Blastomycosis

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presented no problems when given with 20-25 mg. Hydrocortisone per infusion as previously reported[8].

Summary

The need for complete diagnoses and treatment in associated diseases is re-emphasized. A patient with miliary tuberculosis was found to have a superimposed Blastomycosis infection when his initial clinical response to treatment did not follow the anticipated course. Both diseases responded satisfactorily to combined antituberculous and Amphotericin-B therapy.

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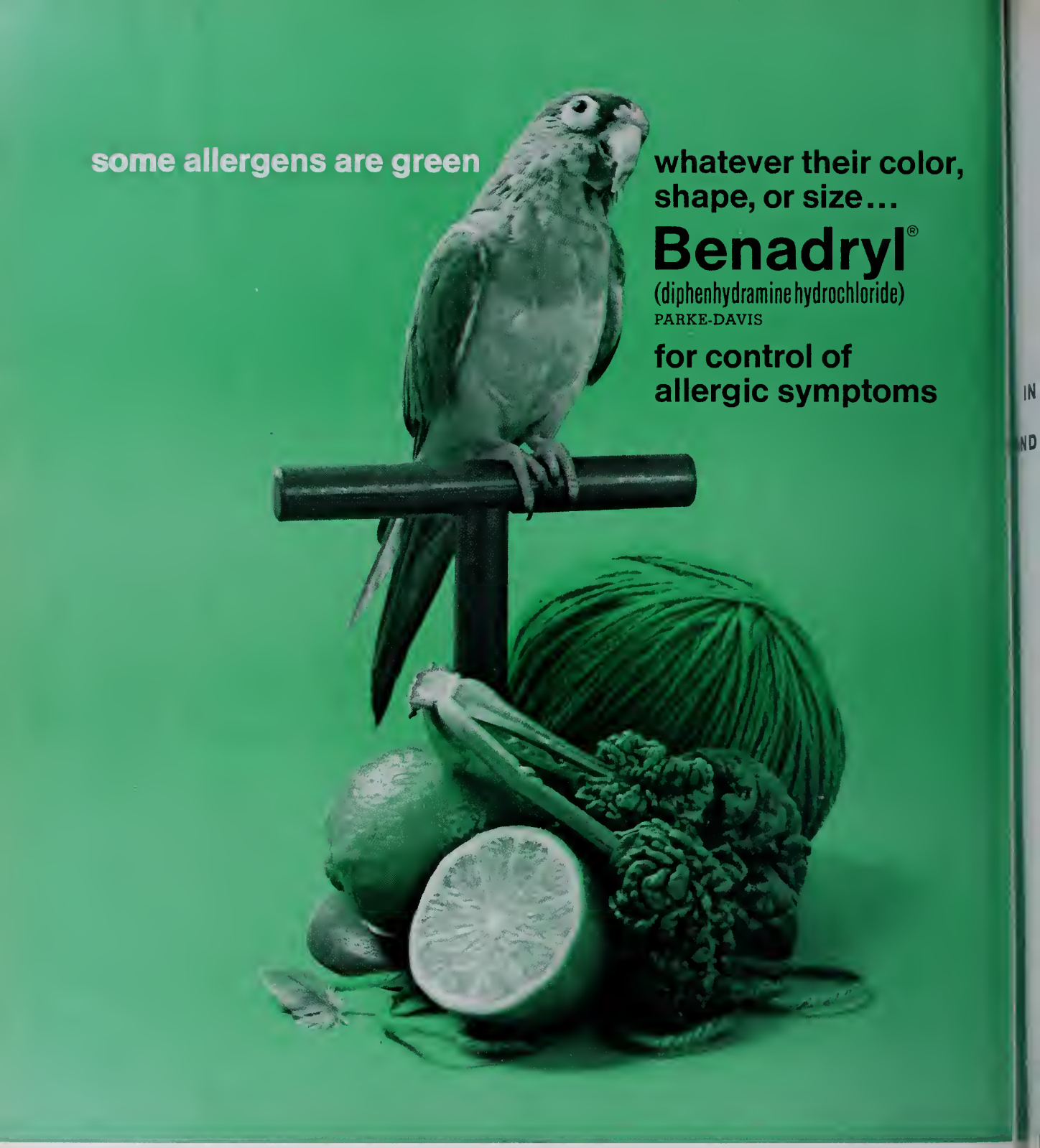
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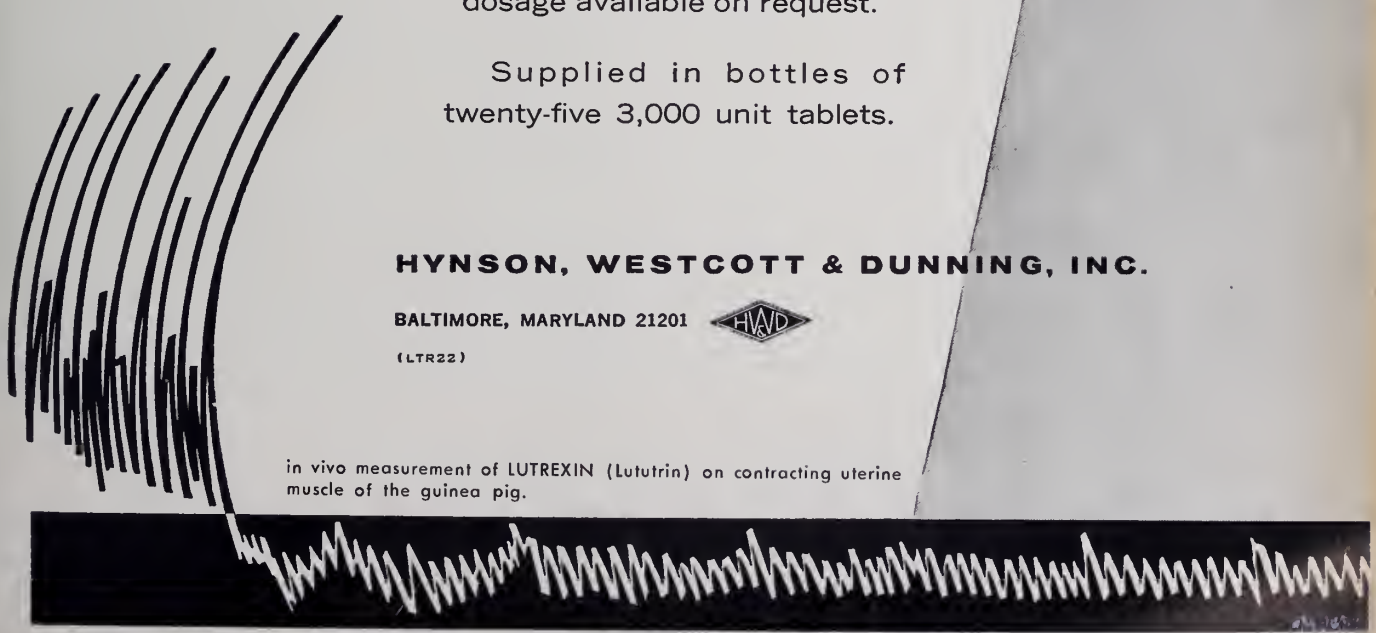
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MESSAGE FROM THE PRESIDENT



DURING the past few years we have seen a tremendous growth and activity in all of our society. This includes medicine as well as all other phases of our economy.

With this aroused interest of the profession, the public and the government in health, it has become necessary to increase the activities of our own medical association. To keep abreast of the rapid and continuing changes in the concept of medical practice, the number of meetings required of committees, officials, and staff of this organization, both within and outside the state, has increased more than 50 percent during the past five years. This has resulted in an increase in cost of operation of KMA and a strain on the budget.

Seventy-five percent of our income is obtained from membership dues. With an increase in the activity of our Association—an apparent necessity if private medicine is to have a voice in determining its future—either more income will have to be found or we must diminish our activities. The latter would result in a decrease in the effectiveness of organized medicine in guiding its destiny.

To continue and increase our operation without increased cost, the Association has, during the past year, had a committee studying the "economy and efficiency" of our organization. This "Hoover Committee" has several changes to recommend to the House of Delegates at our Annual Meeting in September. It is urged that all county societies give these recommendations serious study and that their representatives attend both meetings of the House as well as the reference committees.

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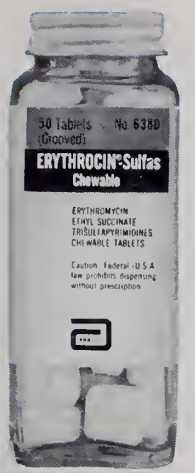
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Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

Tandearil®
oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil® oxyphenbutazone helps painful shoulders move again



3 out of 4 painful shoulder patients responded well

84.2% of 127 patients

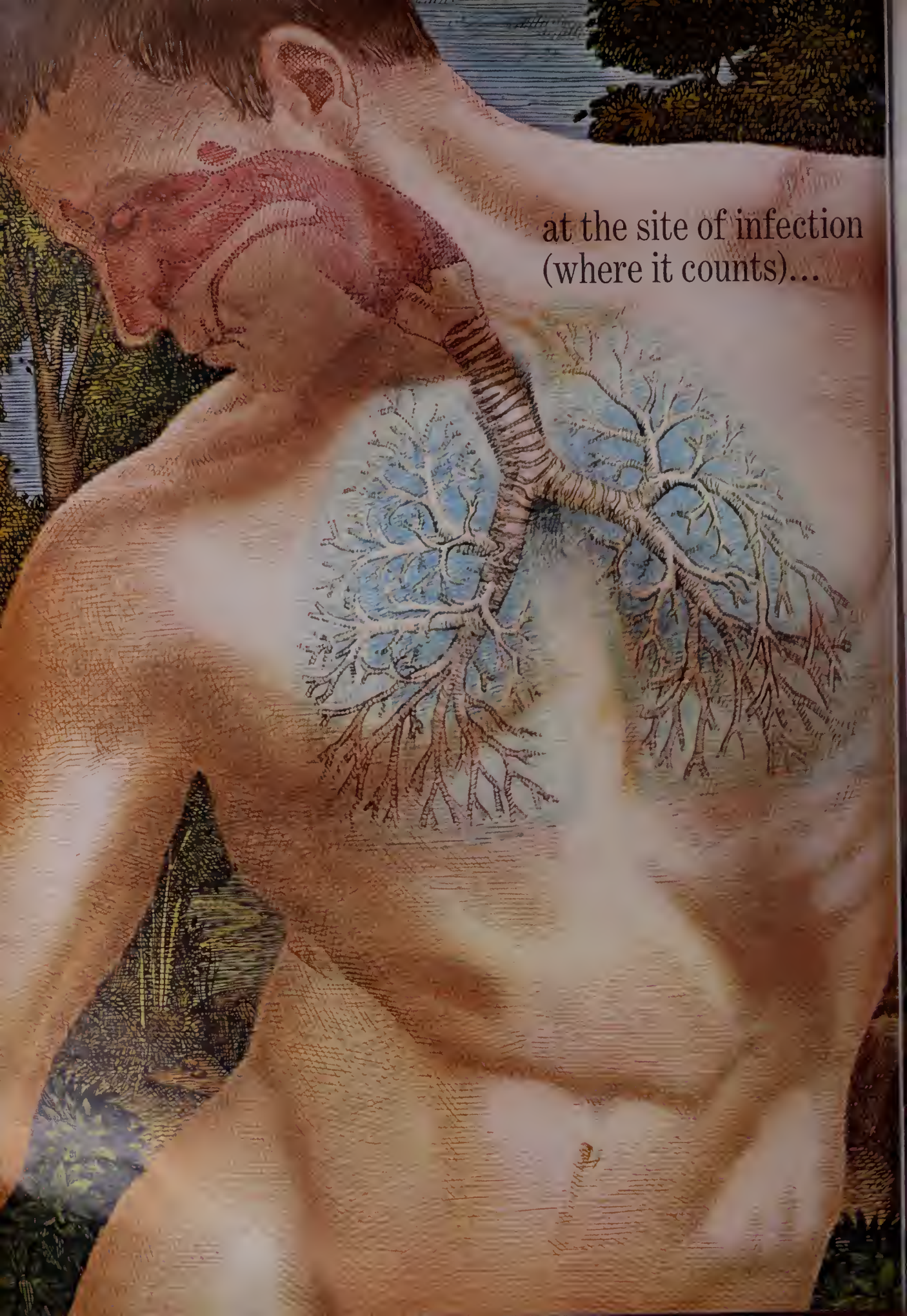
81% of 48 patients

Please see adjoining page for brief prescribing summary

TA-5094PC

Sperling, I L. Applied Therap. 6 117, 1964

Rosenbaum, E. E., and Schwarz, G R. Northwest Med. 61 927, 1962.


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear tnat the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appea be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, el alkaline phosphatase levels, negative or weakly positive ce flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, an mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice h been reported in other patients taking prolonged courses medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six month patients with rheumatic fever have taken prophylactic do 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had ep of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mont rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Ele of SGPT and serum alkaline phosphatase levels during the of treatment was observed in one patient treated with I and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the pen group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients comparable to those in a similar control group who had rec penicillin.

Gastro-intestinal disturbances not associated with hepat fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hour children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual d of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythro therapy should be considered.

In the treatment of syphilis, the recommended total dos 20 to 30 Gm. given in divided doses for a period of ten to f days. Close follow-up of the patient is necessary since ery mycin drugs have not had adequate evaluation in all stag syphilis. Examinations of spinal fluid are recommended as of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four day recommended. In the treatment of gonorrhea, patients w suspected lesion of syphilis should have a dark-field examin before receiving antibiotics, and monthly serologic tests s be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pack

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pack

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to b in bottles of 50. [03

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.



THE INSURANCE PAGE



AMA Position on Health Care Costs

"TODAY . . . the ability of the physician to serve his patient is being handicapped by the rapidly rising prices of the various components of health care." So states a report of the Board of Trustees of the American Medical Association which was adopted by the House of Delegates at the Atlantic City convention.

"Each increase in the price of hospital rooms, diagnostic tests, surgical and medical procedures, or drugs makes it more difficult for the patient to finance his health care needs." "Indeed" the report notes, "if the price of health care continues to outrun slower increases in consumer income, the problem of medical indigence will assume alarming proportions."

The doctor has no control over many of these costs, the reports points out. But to the extent that he can do so, he "must accept the responsibility of helping his patient conserve his health care dollars." Among the steps the physician can take, the AMA suggests reducing hospitalization to the "absolute minimum compatible with quality care," prescribing the least costly effective drugs and weighing the benefits of diagnostic tests against their cost.

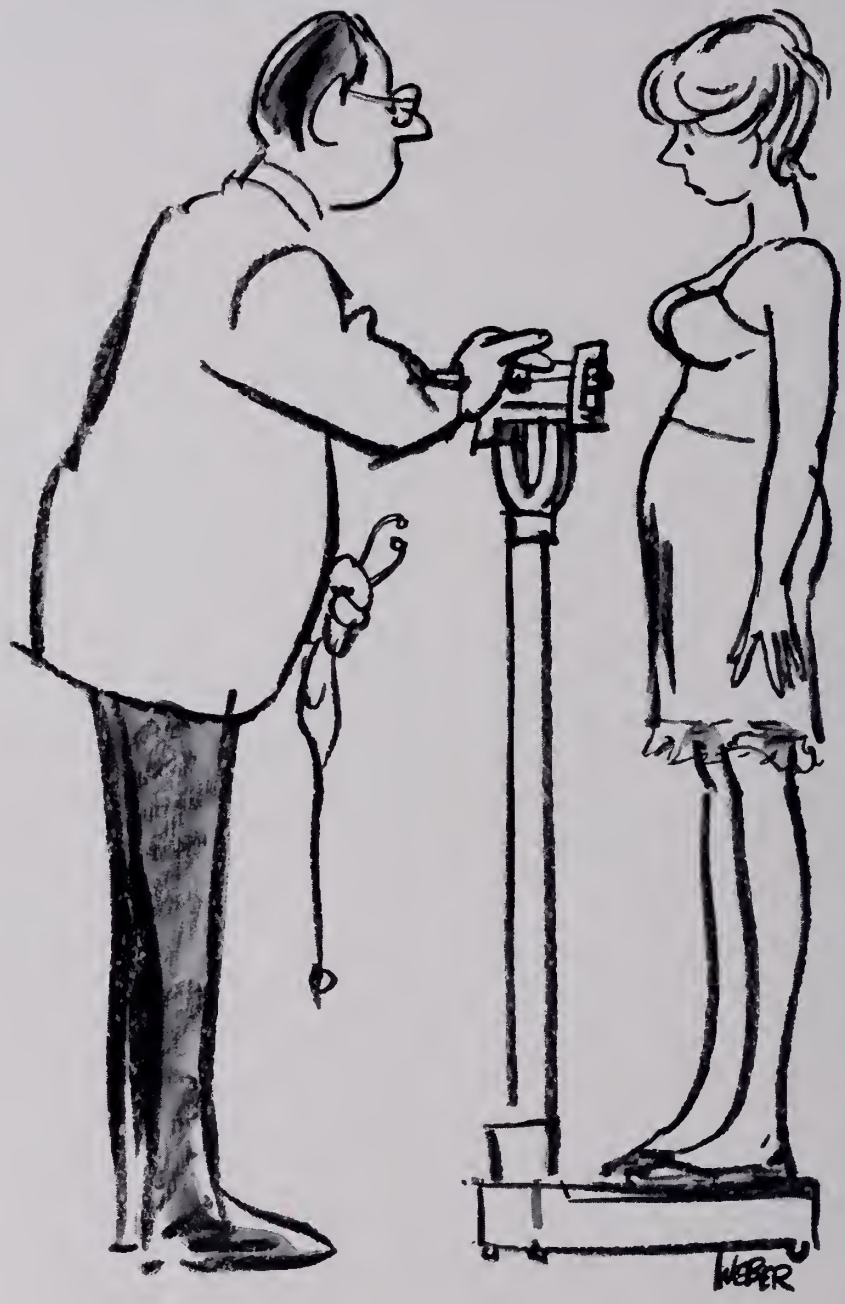
"Physicians must continue their search for ways to increase their own productivity and efficiency so that professional fees can be stabilized and perhaps lowered at times," says the report. "Furthermore, the privilege of a physician to charge usual and customary fees will continue to require prudence."

The report recommends the use of extended-care facilities, nursing homes, and home care, where these can be safely substituted for high-cost hospitalization. It adds: "Voluntary health insurance and prepayment plans must develop more effective means for providing coverage against the cost of care in these lower priced facilities, in physicians' offices, and in the home."

The House of Delegates also expressed concern for patients' finances by action on several other resolutions. One declared that one cause of rising health costs is "unnecessary hospitalization" for diagnostic and minor surgical procedures that could be done as well in doctors' offices or outpatient departments. It blamed these admissions on insurance policies that limit benefits to inpatients. The resolution urged the AMA to work with hospital groups and insurers to modify their policies to include coverage for those who do not enter hospitals.

Another important action was the adoption of a progress report on strengthening and improving voluntary health insurance programs, submitted by the Council on Medical Service. The House accepted the Council's statements that it would "continue to study the scope and patterns of benefits, public demands for coverage, the performance of health insurance and prepayment programs and accumulation of date for future use" and that the Council would "proceed to develop guiding principles for health insurance and prepayment programs."

WILLIAM W. HALL, M.D.



"You're up ten pounds since your last physical. We're going to have to do something about that."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-amphetamine sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

466-7,



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE 13-65. This 38 year old, married, white, gravida 4 para 3 was under the care of a private physician. She was seen initially with the pregnancy under discussion when she was in the eighth month of gestation. The blood pressure was 140/90, VDRL non-reactive and urinalysis negative. She was seen only twice. The next time her blood pressure was 150/80, weight 165 pounds, and urine negative. She had no previous illnesses or surgery. The previous pregnancies had terminated with respectively a stillbirth and a neonatal death after 15-30 minutes. Her last menstrual period was not known; the expected date was estimated at around August 15. The patient's general nutritional state was extremely poor, although she was quite obese.

She was admitted to the hospital in early labor at 1:00 A.M., August 31, 1965 with ruptured membranes, a breech presentation and irregular contractions. The cervix was 6 centimeters dilated, the fetal heart sounds were good, and the blood pressure was 130/80. At 2:00 A.M. the cervix was 8 centimeters dilated, and complete dilation was reached at 2:30 A.M. She received 75 mg Demerol and 1/50 gr Scopolamine. After a second stage of three hours with failure to bring the presenting part past -1 station, she was delivered by classical section of a 7 pound 2 ounces male infant at 7:30 A.M. with sodium pentothal anesthesia. The infant was born alive, but regular respirations were never established and the baby died at 11:30 A.M. A tubal ligation and an elective appendectomy were done before the abdomen was closed at 8:50 A.M. The patient's immediate postoperative condition was described as good. She received 1 gram intramuscularly of Chloromycetin.

She voided initially postoperatively, then had to be catheterized. On September 3 she was still requiring Demerol for pain and Compazine for nausea. Her color was described as ashen, with her skin clammy, her pulse 120, and her abdomen distended. Her blood pressure was 128/102, the pulse rate was 114, the respirations were labored and the lochia were described as foul. The temperature was 101.6°. An electrocardiogram was ordered on September 4 and reported as showing left axis deviation, sinus tachycardia and non-specific T wave changes.

She continued to have difficulty in voiding, and upon catheterization, 200 cc of urine were obtained. A Levin tube was inserted and suction was used to control the nausea. She was maintained on intravenous fluids, and was catheterized at intervals until September 6, when she voided a large amount. She was able to be up with aid, but still required 100 mg Demerol for abdominal pain. The Levin tube was removed at 10:00 A.M. on September 6, 1965. She had dehiscence of her surgical incision on September 7, 1965 and was returned to the operating room for repair at 1:30 P.M. At the beginning of the anesthesia, consisting of sodium pentothal following by nitrous oxide and ether, she had some projectile vomiting of dark brown fluid, with possible aspiration. A Levin tube was inserted and oxygen was administered. The dehiscence was repaired without drainage. At 3:15 P.M. her immediate postoperative condition was described as poor. The intravenous infusion infiltrated in the recovery room twice but was re-started. She also pulled out the Levin tube. The blood pressure was 104/80, the pulse 120, and she felt cold and clammy. One million units of Penicillin were added to the intravenous infusion. Her temperature was 102.6° on September 8, 1965. The patient remained confused, talking constantly, and again partially pulled the Levin tube out. Her blood pressure was 80/2, the pulse 104, weak and irregular, and her condition was described as critical. She died at 6:05 P.M. on September 8, 1965. The cause of death was listed as evisceration secondary to cesarean section.

This was classified as a direct obstetric death with preventable factors. The Committee felt this was an anesthetic death, the most likely cause of death being aspiration. There was no argument with delivery of a frank breech

(Continued on page 818)

There are 32,900* undetected diabetics in Kentucky

Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

Why Wait?



*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

AMES COMPANY, Division Miles Laboratories, Inc., Elkhart, Indiana 46514 428R67

Ames

The KENTUCKY HOTEL is prou
for the KENTUCKY

The Kentucky Hotel is very proud to have been chosen as HEADQUARTERS for the Kentucky Medical Association—not only during Convention time, but EVERY DAY OF THE YEAR.

Elaborate and extensive redecorating and refurnishing improvements now make your stay with us more pleasant. The decorative surroundings and the enhanced facilities combined with the traditionally fine service make every visit an unforgettable experience in the exciting atmosphere of Downtown Louisville.

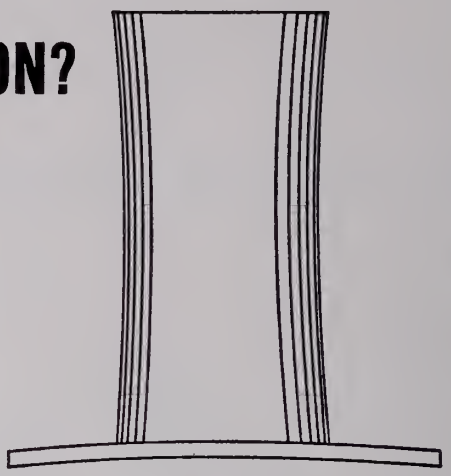
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o be HOSPITALITY HOST
MEDICAL ASSOCIATION



OPTICAL ILLUSION?

Height and width of this hat are equal, but the unbroken height of the crown appears greater than the interrupted width of the brim. Don't play games with your eyes. Some glasses are poorly crafted. Rely on Southern Optical accuracy.



Charge accounts invited

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CONTACT LENSES, 640 S. 4th

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Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

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or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
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Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

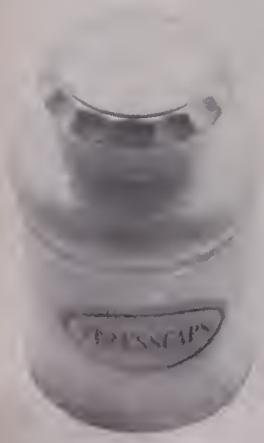
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.
References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.
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The Pastoral Scene†

Ralph G. Thomas, M.D., F.A.C.S.*

Leitchfield, Kentucky

An 11-year experience of doing general surgery in a small rural community in Central Kentucky is presented. On the whole, the author has found much satisfaction in his work.

PERHAPS there is no place on a Scientific Program such as this 1966 session of the Kentucky Surgical Society for such remarks as I would make; however, I applied for 10 minutes of time to present a paper I have chosen to call "The Pastoral Scene". The contents of this report were not known to the program chairman—nor were they questioned. I would beg forgiveness for the very personal nature of these remarks; they are my own. They are sincerely, if not eloquently expressed. They would convey to this body of surgeons a few thoughts which I have not heard given expression at meetings such as this but perhaps may be worthy of a few minutes of time. They represent further, an expression which I feel may be somewhat unique among members of this group. From a glance at Secretary Blaine Lewis' fine printed program, I note that 64 members of this Society practice in Louisville, 36 are listed as from Lexington and 54 of the remaining 55 are listed as practicing in communities of 6000 population or greater. My own practice, entirely limited to general surgery, in its broad sense, is in a community of less than 3000 individuals. Certainly among this largely urban professional gathering, I would qualify as a "country cousin". This qualification, with its implication of a more leisurely pace to all of life's situations, does not necessarily mean that these remarks are to be profound; rather, if there be any point or moral to them, it would be an open expression of joy that I have found in doing surgery in a small rural community in Central Kentucky.

Better than 11 years ago (after a background of public school, college, and medical training largely spent in and around the Cleveland, Ohio area, after residency training at Indianapolis, and after several years of Army Service which included a tour of Inchon, Pusan and Taegu—colorful names to some rather bleak places in Korea), we elected to settle in Leitchfield, Kentucky, the county seat of Grayson County. I first remember it on a warm August day in 1954 as a sleepy, pleasant, good-smelling, friendly sort of place and its special attraction to me was a well-equipped 28-bed County General Hospital, one of many financed by the Hill-Burton Program during that era a decade or so ago. My wife, an excellent nurse and helpmate, and my two daughters immediately found much to like with the place. A few months after we settled there our son was born, the only true Kentuckian of the family, but from the way we all tackle country ham and grits, we would all appear to qualify as well absorbed into the culture of Kentucky. It was not felt that the location in Leitchfield would likely be very permanent—a year or two—then on to bigger things. As I said before, that was 11 years ago.

The first few years were fraught with frustrations and disappointments, but as a certain maturity inevitably developed—and I say

† *Presented at the Annual Meeting of the Kentucky Surgical Society, French Lick, May 13-14, 1966*
* *Surgeon practicing in Leitchfield, Kentucky*

	9/1/54 to 8/31/55	9/1/55 to 8/31/56	9/56 to 8/57	9/57 to 8/58	9/58 to 8/59	9/59 to 8/60	9/60 to 8/61	9/61 to 8/62	9/62 to 8/63	9/63 to 8/64	9/64 to 12/31/65	Total
Gastrectomy	1	2	1	5	3	2	3	1	4	1	2	25
Abdominal Hysterectomy	11	9	32	27	31	35	25	41	59	36	54	360
Vaginal Hysterectomy	1		3	2	2	8	3	12	11	8	24	74
Cholecystectomy	4	8	18	27	23	29	20	39	26	18	33	245
Thyroidectomy		2	5	4	2	6	5	10	9	7	6	56
Simple Mastectomy		1	2	3	3	1		1	1	4	3	19
Radical Mastectomy	1	1	5	1	1	2	1	1	1	1	1	16
Caesarian Section					5	5	8	17	13	13	13	74
Appendectomy	27	58	45	60	50	63	80	90	96	92	128	789
Inguinal Hernia	13	22	27	32	29	23	30	38	35	37	54	340
Umbilical Hernia		2	3	3	6	5		6	2	9	1	37
Femoral Hernia		2	1		1	1		3	6	6	1	21
Ventral Hernia			2						1	1	2	6
Dilatation and Curettage	13	21	37	53	40	45	47	80	66	62	67	531
Debridement and Suture	2	3	1	11	4	12	13	18	25	17	13	119
Incision and Drainage under General Anes.	1	3	1	1	4	4	2	7	15	12	11	61
Fracture, Dislocation Upper Extremity	1	8	24	15	32	18	38	36	38	28	44	282
Fracture, Dislocation Lower Extremity	1	2	6	1	10	2	10	5	7	4	1	49
Hemorrhoidectomy	7	11	10	15	8	6	13	11	10	12	10	113
Fissure-Fistula	2	4	10	4	4	5	1	8	6	4	10	58
Circumcision	2	3	3	3	7	6	5	11	8	5	20	73
Excision Cysts; Tumors, Lipomas, Nevi Fibromas, Ganglions, Polyps, etc.	6	10	21	24	24	32	40	55	43	29	26	310
Closure Perforation Peptic Ulcer	1	2	4	4	4	5	3	3	4	1	2	33
Pelvic Laporotomy with Salpingo-Oophorectomy		1	4	4	6	3	4	8	7	6	4	47
Skin Graft, Burns, Etc.	1	3	3	8	1	1	1	6	6	5	11	46
Exploratory Laporotomy otherwise not listed, Adhesio-Lysis, etc.	2	5	4		3	4	3	6	4	8	8	47
Amputation Fingers and Toes		3	2	1	5	4	7	2	2	9	8	43
Amputation Lower Extremity	1	1		1		2	2	4	2	2	6	21
Tendon Repair	1	2	1	1			4	4	1		1	15
Spleenectomy	1	2	1	1								5
Vein Stripping and Ligation		1	8	4	2	2	2	5	6	3	4	37
Sterilization Male-Female	1			1	1		1	3	2		1	9
Biopsy		3		3	3	2	2		4	1	1	19
Anterior-Posterior Repair			6			2	1	4	1		5	19
Colostomy		1	1					1		1	2	6
Colon Resection	2	1	1		2	3		3	2	1	3	18
Miscellaneous Major	6	5	3	5	5	4	4	5	5	3	6	51
Miscellaneous Minor	14	8	9	4	2	13	17	18	9	11	29	134
Total	122	211	304	327	323	355	395	562	537	457	615	
Grand Total												4,208

FIGURE 1

rather loosely on my part as well as that of the community—the frustrations and disappointments became fewer, and are now largely replaced by a very happy, deep sense of commitment to the surgical needs of our county. Truthfully, Leitchfield is now home, and I envy no man his practice site. As long as there is work for us to do in Leitchfield, that will be our home.

Doing surgery exclusively in a small hospital is certainly not original with me. In an article entitled "Surgery in the Small Community Hospital," which appeared in the June 1964 Archives of Surgery, some interesting statistics were pointed out: 63% of the hospitals in the United States have less than 100 beds; 25% of all in-patients in the United States are found in hospitals with less than 100 beds. While accurate appraisal of surgical procedures done in such hospitals is not available, it seems a fair assumption that a sizable percentage of all surgical procedures are carried out in hospitals of 100 beds or less.

Ralph Adams, M.D., the late professor of

surgery at Boston University School of Medicine, in a paper presented to the session on surgery at the Vermont State Medical Meeting in 1954 entitled, "Big Surgery in Little Hospitals", suggested that the large hospital always has and will probably continue to surpass the small one in reputation, but he felt the time had arrived when the small hospital may equal or excel the large one in service rendered. In his analysis of the "internal workings" of the best large hospitals, he found them sub-divided functionally into services or units of 60 to 70 beds, frequently with such units complete with adjacent laboratory facilities, consulting rooms, diet kitchens, intensive care areas, etc., such that the small unit was nearly autonomous in itself—essentially the same situation as in a small community hospital. Doctor Adams recognized that no better medical service can be found than that which is available in the good teaching centers in this country. From his personal experiences in a small New England Hospital and his work in and around the Boston area, he concluded that operation for operation, results statistically were comparable; that good surgical service could be provided more economically in hometown hospitals; that operations of large magnitude could be done as safely in a 50-bed hospital as a 500-bed hospital.

My own experience in Leitchfield—which now boasts a 54-bed hospital bursting at its seams—would tend to amplify Doctor Adams' conclusions. I have tabulated a good portion of my 11 years work in this small hospital. There are no aortic resections—no kidney transplants—but I do point with pride to some 800 cases of appendicitis—operated upon without mortality. There has been much personal satisfaction in carrying out the first common duct exploration in Grayson County, the first thyroidectomy, the first radical mastectomy, the first splenectomy and many others of lesser consequence. The challenges have been varied and always stimulating. The tabulated figures show a total of 4,202 operations with a mortality rate of less than 1%. (See Figure 1.)

"The Pastoral Scene" to me is not all a matter of statistics, however; I find it hard to define. It is the close relationship I enjoy with my patients—better called my friends; I would question if anyone in this room lives as closely with his operative results as I do, and I get up each morning eager for the new day. It is the close relationship I have enjoyed with my big city colleagues 80 miles away—but always eager to lend a hand—generous with their praise and helpful to our patients. It is the intimate knowing of one's fellow practitioners, their strengths and weaknesses, their personalities and their capabilities that small town living provides. It is the practice built on respect and mutual dedication. It is the feeling of doing a job that needs doing, of filling a spot that needs filling, of being useful, occasionally but rarely heroic, but nearly always needed and appreciated. "The Pastoral Scene" is a confining scene but it has become for me a way of life, and it pleases me.

I am grateful to this Society for the privilege of relating my experiences. "The Pastoral Scene" has been good to me; I would recommend its consideration to any young surgeon.

Lipoma with Bizarre Cellular Change†

YUNG KOOK IM, M.D.*

Covington, Kentucky

A report of two cases of lipoma with unusual morphological structures which had recurred on three or four occasions and a discussion of the unusual variants of the lipoma.

Introduction

RECENTLY we learned of two cases of lipoma with unusual morphological structures and which had recurred on three or four occasions. During this period 124 adult lipomas were encountered among the surgical specimens—16,020 cases. The author's purpose in this paper is to report the two cases and to dicuss the unusual variants of the lipoma.

Case 1

The patient was a 63 year old, white male who noticed the recurrence of a tumor of the right spermatic cord for about two months prior to admission. The tumor had recurred over three times in the past 10 years.

Physical examination revealed a moderately firm, non-tender tumor of the right spermatic cord near the upper pole of the testicle. The laboratory studies revealed a hemoglobin of 13.6 gm. per 100 ml., hematocrit 46 vol. per 100 ml., leukocytes 10,450 per cu mm. Urinalysis, normal.

The clinical impression was "probable liposarcoma of the right spermatic cord" and a right orchidectomy was performed on December 4, 1963. The specimen consisted of the right testis and the spermatic cord with tumorous nodule. The gross appearance of the tumor was a myxoid soft nodule, well delineated, 4 cm. in diameter, attached to the spermatic cord, and the tumor was surrounded by adult fatty tissue. (Fig. 1)

Histologic preparations of the tumor revealed lobulated fat tissue with little vascularity on scanning. Tumor cells consisted of proliferating cells with irregular size and shape of cytoplasm and nucleus in myxoid stroma. Some of the larger cells showed centrally located, large nuclei with fine radiating streaks in cytoplasm which are similar to the so-called lipoblast. (Fig. 2) Also multinucleated cells



FIGURE 1. Well-delineated, soft tumorous nodule



FIGURE 2. Lipoblast-like cell at the center

† *Presented at the Annual Meeting of the Kentucky Medical Association, September 20, 1966*

* *Assistant pathologist, St. Elizabeth Hospital Laboratory*



FIGURE 3. Note many scattered large cells with various shapes

were seen. (Fig. 3) Fat stains, including Sudan IV, Sudan Black and Nile blue sulfate, were entirely negative. Also other special stains, such as PAS, trichrome and PTAH, were non-contributory, except Alcian blue which showed occasional blue positive material in cytoplasm of large cells.

Follow-up: asymptomatic, living and well (as of August 1965).

Case II

This patient, a 62 year old, white female, was admitted with recurrent retroperitoneal lipoma. She had five recurrences in the past 26 years. Her past history is as follows: in 1930 (when she was 27 years old) a 17 lb. lipoma was removed from the region of the right kidney. Subsequently she was operated for a recurrent lipoma (7.5 lb.) in 1940. In 1946 a retroperitoneal lipoma was removed again and a consultation was sent to Mayo Clinic. James Mason, M.D., replied that local recurrence of this lipoma is quite common and unless all the lipomatous tissue is removed, they tend to recur locally with a tendency to become malignant. A recurrent lipoma was removed again in 1959 and in 1965 with a total of five recurrences.

Physical examination revealed a round, nontender mass, about the size of a baseball, located at the center of the right rectus scar of the abdomen. The laboratory studies reported the hemoglobin as 11.6 gm. per 100 ml., hematocrit 38 vol. per 100 ml., leukocytes 6300 cu mm. Urinalysis was normal. The clinical impression was "recurrent retroperitoneal lipoma." Surgical exploration was done and the lipoma was removed with the help of indwelling ureteral catheter. Postoperative recovery was uneventful. The specimen consisted of lobulated fatty tissue, 880 gm. (21 x 15 x 4 cm.). Most of the tumor tissue was adult lipoma except for one focus which showed slightly white in color with no significant change in consistency. The histologic preparations from this area showed adult fatty tissue with occasional mixed large cells with multilobulated nucleus. (Fig. 4) Fat stains, (including Sudan IV, Sudan black and Nile blue sulfate), revealed no sudanophilic material in cytoplasm of large cells. PAS and trichrome stains were non-contributory. Alcian blue showed strong blue positive material in most of large cells.

Follow-up: no evidence of recurrence (as of April 1966).

Discussion

Fatty tissue with ischemic and inflammatory changes, such as mesenteric fat in strangulated hernia, shows proliferating large cells which are more or less the fibrocytic type or with some myxoid stroma, but not tumorous.

Pack and Pierson[1] mentioned that the pseudo-encapsulation of the average liposarcoma suggests its benignity and tempts the first surgeon unwisely to perform a simple enucleation. The recurrent liposarcoma does have invasive propensities and infiltrates muscle, fatty tissue and skin. In 1938 Gricouroff[5] described myxoid lipoma of "lipoma embryonnaire" which can behave like a malignant tumor by recurring or metastasizing. He placed them between simple lipoma and atypical liposarcoma. Mucin carmine will stain the intercellular substance but never intracellular vacuoles which contain lipid. He points out that these tumors may have an area resembling



FIGURE 4. Few large odd-shaped cells, otherwise adult lipoma

fibrosarcoma poor in collagen as well as myxoid areas.

Stout[3] compared well-differentiated myoxid type of liposarcoma to the usual type embryonal fat histologically. Embryonal stellate or spindle-shaped fat cells contain droplets of a material which can be stained with Scharlach R. or Sudan III and usually a rather rich network of capillaries.

Vellois, Baez and Shumacker[4] reported a case of lipoblastomatosis; also histologically this lesion resembled fetal fat with lobular pattern, richly vascular; many cells are vacuolated and proved to be sudanophilic.

It is assumed that any lipoma with a tendency of recurrence is considered to be a low-grade liposarcoma biologically. The present tumor would not be classified well as a liposarcoma because of the lack of infiltrating growth after recurrences, and because the fat stains are negative. Fat stains are entirely negative in Case I; however, no sudanophilic material is present in the large cells in Case II. Also most portions of the tumor (Case II) are adult lipoma except focal sarcomatous change.

Summary

Two cases of recurrent lipoma with unusual morphology are presented. This tumor seems to belong somewhere between benign lipoma and liposarcoma. The surgeon should be informed that this kind of tumor is prone to recur, and a wide excision rather than the conservative way is the choice of treatment.

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Arsenic Polyneuropathy

M. Allen Dawson, M.D.*

Lexington, Kentucky

Arsenic is now a relatively rare cause of polyneuropathy. Treatment should include BAL, even though neuropathy may follow arsenic ingestion by as long as eight weeks.

ARSENIC polyneuropathy, formerly quite common, is now relatively rare[1,2]. In the early part of this century, the neuropathy was usually due to contact with arsenic-containing household articles such as dyes, wallpaper and pesticides. Such exposure to arsenic has been reduced in recent years, and medications such as Fowler's solution and the arsphenamines are rarely used at present.

BAL (2,3 dimercapto-propanol) is usually recommended for the treatment of arsenic poisoning [3,4,5], but its value in polyneuropathy appearing several weeks after ingestion of arsenic has been questioned[1,6].

This report summarizes a case of polyneuropathy seen eight weeks after arsenic ingestion. In contrast to the experience of others[1], improvement after administration of BAL was rapid.

Case Report

A 28-year-old man entered the USPHS Indian Hospital because of difficulty in walking.

Sixty days previously, he had been on a drunken spree and mistakenly drank an unknown amount of Cowley's Rat Poison (containing arsenic trioxide 1.75%). He could recall little of his illness immediately after ingesting the poison, except that he felt well in three days.

One week prior to admission, numbness, burning pain and tingling of the hands and feet began. Ankle edema, cramping calf pains, difficulty in walking and stiffness of the joints in all four extremities were also noted. There was no history of eyelid edema, difficulty with vision, headache, drowsiness or complaints referable to the skin. He denied recent consumption of alcohol. The past medical history was unremarkable.

Physical examination revealed a well-nourished man who appeared chronically ill. The temperature was 99.4°F., the pulse 80, the respirations 20. The blood pressure was 170 systolic, 100 diastolic. The conjunctivae and optic fundi were normal. The posterior pharynx was moderately injected. The lungs were clear and the heart was normal. The liver and spleen were not felt. The genitalia, rectum, and prostate were normal. There was no ankle edema. The skin was normal and the nails had no transverse furrows or opacities. There was gross ataxia of all extremities. Weakness of the calf muscles and grip was pronounced. There was no foot drop. The tendon reflexes in the ankles were absent. He had decreased sensibility to pain, touch, and vibration in the feet and hands in a stocking and glove distribution. The gait was markedly ataxic, and he walked only with great difficulty.

The urine was normal. The hematocrit was 42%; the hemoglobin was 14.1 grams %; the white cell count was 6,500/mm^3, with 70% neutrophils, 25% lymphocytes, 3% monocytes, and 2% eosinophils. The blood smear was normal and the platelets appeared adequate. The mean corpuscular hemoglobin concentration was 33.6%, and the reticulocyte count was 0.2%. A stool examination revealed trophozoites of *Giardia lamblia*. The urea nitrogen was 10 mg.%; the bilirubin was 1.0 mg.%, of which 0.35 mg.% was direct-reacting. The glutamic pyruvic transaminase (SGPT) was 16 units, and the alkaline phosphatase was 3.5 Bodansky units. The hair contained 3.9 mg. of arsenic per 100 grams. Nail parings contained 1.1 mg. of arsenic per 100 grams. The urine arsenic was 57 micrograms in a 24-hour specimen.

BAL was given (2.5 mg. per kilogram of body weight) intramuscularly every four hours for six injections, then every six hours for four injections, then every twelve hours for two injections, and then daily. Except for the day of

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admission, he was normotensive and the pulse was normal. After four injections of BAL, he complained of a transient increase in burning sensation; no other side effects were noted. One day later, tingling sensations had disappeared, and he had considerably less numbness. Five days after the beginning of BAL therapy the gait was less ataxic. Two weeks later, he walked with only slight ataxia. BAL was given for 30 days; neurological examination on discharge from the hospital was normal except for slight impairment of position sense in the legs. Urine arsenic on the thirteenth and twenty-sixth days after beginning BAL was 77 and 112 micrograms per 24 hours, respectively.

Discussion

Following its ingestion, arsenic is deposited in the skin, liver, spleen and kidneys; in addition, it causes axis cylinder disintegration and myelin fragmentation in peripheral nerves. Acute poisoning causes nausea, vomiting, diarrhea, burning of the throat and severe abdominal pain[3]; circulatory collapse and death may follow. Chronic poisoning may be manifested by hyperkeratotic skin, opaque (Mees) lines in the nails, pharyngitis and conjunctivitis, and edema of the face and extremities. Renal involvement produces proteinuria, microscopic hematuria and aotemia. Anemia, leukopenia, thrombocytopenia, and basophilic stippling may be noted[8].

Peripheral neuropathy may occur in chronic exposure. The onset of neuropathy after acute poisoning is usually delayed for four to eight weeks[2]. The clinical picture of arsenic neuropathy includes burning pain, paresthesias, sensory loss and weakness in the extremities. The feet are usually more severely involved, and the tendon reflexes are generally absent at the ankles.

Since 1948, the treatment of arsenic polyneuropathy has included the administration of BAL. However, the efficacy of this agent when given several weeks after arsenic ingestion has been questioned. Heyman, et al.[1], reviewed 41 cases of arsenic polyneuropathy; 22 were treated with BAL. In their series, the early signs of improvement did not occur until six weeks after onset of neuropathy, and significant changes did not occur until 10 to 12 weeks later. There was no significant difference in recovery time in the treated and untreated groups. In contrast to their experience, the patient reported here began improving two weeks after the onset of neuropathy five days after the beginning of BAL therapy) and recovery time was essentially complete after another three weeks. This suggests that BAL should be administered whenever peripheral neuropathy is due to arsenic poisoning.

Summary

A 28-year-old man with severe polyneuropathy was seen eight weeks after he had ingested arsenic. In spite of this long interval, the administration of BAL was followed by complete recovery.

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Pulmonary Surgery for Tuberculosis In Diabetic Patients†

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and Carlos H. Rivarola, M.D.***

Louisville, Kentucky

This study confirms the fact that diabetes mellitus is not a contraindication to pulmonary surgery in tuberculosis and that patients with these two diseases respond well to surgical management.

THE tuberculous diabetic, once considered a very difficult management problem, has been regarded in recent years with relative equanimity from a therapeutic standpoint. Since the advent of the anti-tuberculous drugs, as well as insulin and the oral anti-diabetic agents, medical therapy of this combination of diseases has been quite successful.[1,2,5,6]. Cavity closure rates as high as 81%, and sputum conversion rates of 94% have been reported in these cases.[2].

Several reports indicating good results in the surgical management of these patients have also appeared recently[3,4]. We wish to reports our experience with 40 tuberculous diabetics who were treated by pulmonary resection or thoracoplasty.

Clinical Material

Forty consecutive diabetic tuberculous patients who underwent pulmonary surgery from 1950 through 1964 provided the case material for this study. The data obtained from the charts were extracted and were deemed adequate for the preoperative evaluation as well as for the immediate and long term follow-up status. The indication for surgery in these cases was persistent cavitation and/or persistent positive sputum despite an adequate medical regimen.

Results

The age range of these 40 patients was from 19 to 62, with 22 males and 18 females. Ten of these patients were under the age of 30 and could be considered as juvenile diabetics. The severity of the diabetes was roughly classified according to the average fasting blood sugars as follows: Less than 150 mg.% — eight cases; between 150-250 mgs.% — 16 cases; more than 250 mgs.%—16 cases. (See Table I). The control of the diabetes was considered adequate and satisfactory in all patients in the immediate pre-operative period, based on the absence of ketosis or hypoglycemic episodes, and the absence of, or very slight glycosuria. Only five patients were controlled with an oral antidiabetic agent alone, the remainder being maintained with NPH and/or regular insulin. Dietary restrictions were individualized in each case as well.

TABLE I
SEVERITY OF DIABETES ACCORDING TO AVERAGE FASTING BLOOD SUGAR

	No. of Pts.
MINIMAL (Less than 150 mg.%)	8
MODERATE (Between 150-250 mg.%)	16
SEVERE (More than 250 mg.%)	16

As to the classification of the tuberculosis, there were 30 patients with far advanced disease; eight with moderately advanced disease and two with minimal disease. Twenty-three patients had bilateral involvement. Cavitation was noted in 27 patients; bronchiectasis in 14, and pneumonitis and fibrosis in 12 patients (See Table II). Some had more than one finding on the x-ray. The sputum status indicated that 25 were positive on admission, 12

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***Clinical Instructor in Medicine, University of Louisville School of Medicine*
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TABLE II
CLASSIFICATION OF TUBERCULOSIS AND X-RAY APPEARANCE

	No. of Pts.
FAR ADVANCED	30
MODERATELY ADVANCED	8
MINIMAL	2
BILATERAL DISEASE	23
CAVITARY DISEASE	27
BRONCHIECTASIS	14
PNEUMONITIS - FIBROSIS	12

(Some had more than one x-ray finding.)

remained positive preoperatively, and post-operatively four remained positive, but later converted to negative (See Table III).

TABLE III

SPUTUM STATUS	POSITIVE	NEGATIVE
ON ADMISSION	25	15
PREOPERATIVELY	12	28
POST SURGICAL	4*	36

*These 4 patients later converted to negative.

As to the type of surgery performed, resectional procedures were done in 38, with two patients having the Monaldi thoracoplasty. The further breakdown of the surgical procedures is indicated in Table IV.

TABLE IV

TYPE OF SURGERY	No. of Pts.
SEGMENTAL RESECTION	10
LOBECTOMY & SEGMENTECTOMY	10
LOBECTOMY	7
BILATERAL SURGERY	4
BILOBECTOMY	2
PNEUMONECTOMY & THORACOPLASTY	2
WEDGE RESECTION	2
MONALDI THORACOPLASTY	2
PNEUMONECTOMY	1

Surgical complications were divided into the early (that is, occurring in the first four weeks), and the late complications. The early type occurred in 20 patients and consisted primarily of atelectasis, but there were also two cases of pulmonary embolism, one each of air space, bleeding and empyema. The late complications (those occurring after four weeks) included spread of tuberculosis in four patients, bronchopleural fistula in four, empyema in two and wound infection in one. (See Table V).

Postoperative diabetic complications consisted of acidosis and ketosis, which developed in four patients. Also, hypoglycemic episodes of mild degree occurred in five, and coma in one (See Table VI). These diabetic complications occurred with the regimen of a sliding scale dosage of insulin in the post-operative period, based on the spillage of urine sugar, giving five units of regular insulin for each 1 plus. The one case of coma was attributed to a cerebrovascular accident, which occurred postoperatively, and made the diabetic management more complicated and difficult. Post-operative improvement in the diabetic status from the standpoint of lessened requirement of insulin was not thoroughly evaluated, but was not thought to take place.

Surgical deaths totaled six. There were three early deaths, two attributable to pulmonary emboli, occurring on the third postoperative day, and one occurring on the 78th postoperative day, after the development of a right hemipareses and a very labile diabetic control, with bouts of hyper and hypoglycemia. (This is the case referred to above as having sustained a cerebrovascular accident.)

There were also three late deaths, occurring at one, two and three years respectively. All patients expired at home, and it is presumed that their tuberculosis was under control at the time of death. Thus, 34 patients remained alive and well, giving an over-all 85% favorable result in the surgical management.

Reactivation of tuberculosis occurred in seven of the 40 patients (17.5%). The average in the non-diabetics in this institution is approximately 10% reactivation.

Discussion and Summary

The results of our experience with 40 tuberculous diabetic patients who underwent pulmonary surgery have been analyzed. The long term results indicate that of these 40 patients, 34 at this time are living and well, with three early deaths having occurred and three late deaths following surgery. Although these results are not as good as might be expected in the non-diabetic, it is still considered to be a satisfactory rate of cure in these cases.

TABLE V

SURGICAL COMPLICATIONS	No. of Pts.
A. EARLY COMPLICATION (First 4 weeks)	
ATELECTASIS	13
AIR SPACE & ATELECTASIS	3
AIR SPACE	1
BLEEDING	1
WOUND INFECTION	1
PULMONARY EMBOLISM	1
EMPYEMA	1
B. LATE COMPLICATIONS (After 4 weeks)	
TUBERCULOUS SPREAD	4
BRONCHOPLEURAL FISTULA	4
EMPYEMA	2

The indication for surgery was not altered

(Continued on page 811)



Records in Attendance and Number of Resolutions Considered Set by AMA Delegates at Annual Session June 18-22

The following summary of the action of the AMA House of Delegates at the June 18-22 Annual Session in Atlantic City is presented here because of its importance to you as a KMA member. The report, prepared by F.J.L. Blasingame, M.D., executive vice-president of the AMA, covers only some of the important subjects considered by the House and is not intended to be a full and detailed report on all actions taken.

The Editors

TWO records were set at the 1967 Annual Session of the AMA House of Delegates in Atlantic City, June 18-22. One of these records relates to attendance, with two of the four sessions having 100 percent attendance of 242 delegates.

The House considered a total of 123 resolutions for a new record. In addition, the delegates acted on 28 reports from the Board of Trustees, councils and committees. A summary of the action of the House on these resolutions and reports follows.

Therapeutic Abortion

One subject that has generated interest not only in the profession but among legislatures and the public is therapeutic abortion.

The House updated the Association's 1871 policy on the subject which, according to the Reference Committee report which was adopted, was not only antiquated but lacked even the rudiments of adequate safeguards to prevent abuse. The updated policy, the House agreed, is in keeping with modern scientific knowledge, contains necessary safeguards and permits the physician to exercise his personal conscience and medical judgment in the best interest of his patient, over-riding objectives in any medical decision.

The following was established as policy of the American Medical Association:

". . . Recognizing that there are many physicians who, on moral or religious grounds, oppose therapeutic abortion under any circumstances, the American Medical Association is opposed to induced abortion except when:

"(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

"(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

"(3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;

"(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

"(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

"It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion."

Health Care Cost

"Today . . . the ability of the physician to serve his patient is being handicapped by the rapidly rising prices of the various components of health care." That is a statement from the Board of Trustees report adopted by the House with the provision that it be widely disseminated for study and evaluation as to its applicability in local areas.

"Indeed," the report continued, "if the price of health care continues to outrun slower increases in consumers' income, the problem of medical indigency will assume alarming proportions."

Basic problems in the over-all design of the nation's health care system, as shown in the adopted report, include inadequate numbers of new physicians and shortages of other individuals trained to function as part of the health care team; the present organization and management of the nation's hospitals, with respect to their "privilege of automatically translating all higher costs into higher prices" which "must now be questioned;" diagnostic and therapeutic care outside of a hospital; and legislation in the health field.

A number of actions were taken to outline possible solutions to the problems of higher health care costs. One important one was the adoption of a progress report on strengthening and improving voluntary health insurance programs, submitted by the Council on Medical Service. The House accepted the Council's statements that it would "continue to study the scope and patterns of benefits, public demands for coverage, the performance of health insurance and prepayment programs and accumulation of data for future use;" and that the Council would "proceed

to develop guiding principles for health insurance and prepayment programs."

As further efforts in this direction, the House referred to the Board and to the Council on Medical Service a resolution that the AMA "consult with insurers in an effort to change their policy of insurance coverage so that payment can be made for diagnostic procedures and minor surgery performed in the physicians' office and/or in the hospital outpatient department;" adopted a resolution that the Association petition congress to remove the restriction on first-dollar deduction from income tax laws for health care expenditures; and adopted the over-all policy that "physicians . . . continue to do everything possible to help the public conserve its health care dollars."

Government Health Programs

As might be expected, a great many reports and resolutions dealt directly or indirectly with the Association's relationships with government and with the multitude of government programs existing or proposed in the health field.

The House re-affirmed Association policy that "The medical profession has long and consistently held to two basic positions concerning personal health care and its financing: that no one should go without needed care because of inability to pay, and that responsibility for payment rests first on the individual himself and then, to the extent that he is unable to pay, on his family, the community, the county, the state, and, to the extent that lesser levels of government are unable to finance the care, the federal government."

Regarding the Title XIX program, the House made it policy that "the medical profession should now take a firm stand in support of the Title XIX approach in improving the health and the delivery of health care services to the needy of the nation."

Recommendations adopted by the House are that the medical profession take a strong stand in support of implementation of Title XIX "while still seeking such changes in the federal legislation and/or regulations as will improve this program; that it urge organized medicine to take a leading role in formulating and directing Title XIX programs at the state and local level . . . and that it incorporate in such planning the use of existing voluntary mechanisms and private insurance carriers, wherever feasible, utilizing the usual and customary fee principle, thus bringing within the mainstream of present medical care systems the provision of quality health care for all Americans."

Appalachian regional health programs were the subject of a number of resolutions and the House adopted the following guidelines for setting up any such programs: (1) demonstrated need for the proposed project; (2) local control; (3) participation of a significant proportion of local physicians in planning and development of the project; (4) the operation of any regional, area or county health service facility shall not infringe upon the private practice of medicine; (5) all health services, whether preventive, prophylactic or therapeutic, shall be rendered at a cost to the patient commensurate with the social and economic status of the patient; (6) there shall be adequate medical representation on all national, state and local bodies having supervision or jurisdiction in the development and/or operation of such health service facilities; (7) these health service projects shall in no way be developed, operated or influenced in any manner which could lead to a government-controlled system of medical practice.

More generally, in connection with any and all government medical care programs, guidelines were adopted by the House:

"The medical profession in any community is best represented by the local medical society and its officers. They should be consulted initially, and during the process of planning of any and all projects for the care of the sick and the preservation of health."

In proposing any new facility, "It shall be first determined that existing facilities are so inadequate that only a completely new facility will provide a solution.

"The responsibility for the health needs of a community basically resides at the community level, and all the local resources . . . shall be examined before the community accepts government monies.

"If it is deemed advisable to operate a government-financed facility in a community, it shall in no way be binding upon a physician to refer his patients there; to coerce a physician to service the facility; and this facility must in no way infringe upon the private practice of medicine.

"These projects should not be developed or operated in such a manner as to establish a precedent that could lead to a governmental controlled medical care system in this country."

Physician Control Over Collection and Disbursement of Professional Fees

In adopting a report of the Council on Medical Service regarding collection and disbursement of professional fees, the House reaffirmed past action and provided clear, consistent policy statements reflected in these thoughts which are elaborated in the full report:

1. It is proper for the physician to establish the fee he charges to any patient for professional service rendered, with the recognition that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.

2. It is proper for third party agencies to make payment of professional medical fees for patients.

3. It is proper for a physician to work with other physicians in a team approach to the provision of medical service, recognizing that each is entitled to compensation according to the value of his services and that charges attributable to each physician's service shall be made clear to the patient.

4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.

5. A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for him unless it is with the consent of the physician and of the medical staff.

6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under

their own control, which they may support as they see fit, disburse as they may agree.

7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.

8. The physician is the sold arbiter as to the ways he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

Millis Commission and Commission on Research

Because the contents of the Millis Commission report (Citizens Commission on Graduate Medical Education) relate so specifically to the roles of the Councils on Medical Education and Medical Service, the two councils have assumed responsibility for assembling critiques and information. At a later date, they will bring to the Board, and subsequently to the House, recommendations for implementation of parts or the whole of the report. The House urged all interested members of the Association or groups to submit comments, suggestions or recommendations for consideration by the two councils.

With respect to the Commission on Research, the Board has established a Committee on Research to review reports on the subject from the Councils on Medical Education and Medical Service; refer portions of the report to other councils and committees; and confer with those groups in addition to receiving their reports.

Again, the House urged any interested individuals and groups to forward comments and suggestions to the Executive Vice President for transmittal to the committee.

Medicine and Osteopathy

The House adopted the following recommendations of the Board regarding the medical profession's relationships with osteopathy:

1. Authorize the Board of Trustees to begin promptly negotiations directed toward beginning official change of schools of osteopathy to schools of medicine. (It is understood that from the American Medical Association funds will be required to conduct these negotiations, and assistance in identifying and securing additional funds from other sources to support efforts toward changing the schools.)

2. Authorize the Council on Medical Education to undertake negotiations to establish means by which selected students with proven satisfactory scholastic ability in schools of osteopathy may be considered by schools of medicine for transfer into medical school classes.

The primary issue in the relationship of medicine and osteopathy, as recognized by the House, seems to be not that of cultism as opposted to science. Rather the issue appears to be one level of medical education and practice as opposed to another and lower level of education and practice. The extensive and growing licensure of osteopathic physicians for the unrestricted practice of medicine and the nature of osteopathic education strongly indicate that time alone will resolve shortly the problem of cultism in relation to osteopathy.

Medical Manpower

The House accepted for information a report from the Board which pointed out that "The production of well qualified physicians in adequate numbers is necessary to meet effectively both social and economic demands for health care." It reviewed some of the activities of the Committee on Health Manpower and concluded that "The AMA should continue to study the effect of new roles for health personnel and new interrelationships and interdependencies between health professionals, as well as the impact of innovative concepts on the organizational structure evolving in the general system of health care delivery. . . .

"In any event, our resolve should always be as it is now: to use the best tested and most forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated and highly skilled physicians."

The House also referred to the Board, for consideration by the committee, a resolution that "deliberations include strong emphasis on sound ways of accelerating medical education in all its phases, including post-MD and graduate education, and of increasing the supply of physicians in all categories."

In addition, the House adopted reports calling for revision of the Essentials of Approved Residencies in radiology, obstetrics and gynecology; adopted a resolution calling for the promotion of better practices in inhalation therapy; and adopted a resolution that the AMA reaffirm its support of all forms of nursing education; that hospitals which conduct diploma schools of nursing be commended; that such hospitals be urged to continue their school and increase enrollment; and that the AMA take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards.

Committee on Planning and Development

At the June, 1966, convention of the House, the Board announced the appointment of a committee to study planning and development techniques within the Association. The report of the committee was received and the Board submitted its final report to the House at this convention.

The Board voted to (1) establish a permanent Committee on Planning and Development and (2) select seven active members of the AMA as members. The following charges were established for the committee:

1. Study and make recommendations concerning the long-range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them.

2. Serve as a focal point for the planning activities of the Association and stimulate and coordinate planning activities throughout the organization.

3. Study, or cause to be studied, medicine and the environment in which the Association must function and transmit the conclusions of these studies to the Board.

In the report adopted by the House, the Board

(Continued on page 814)

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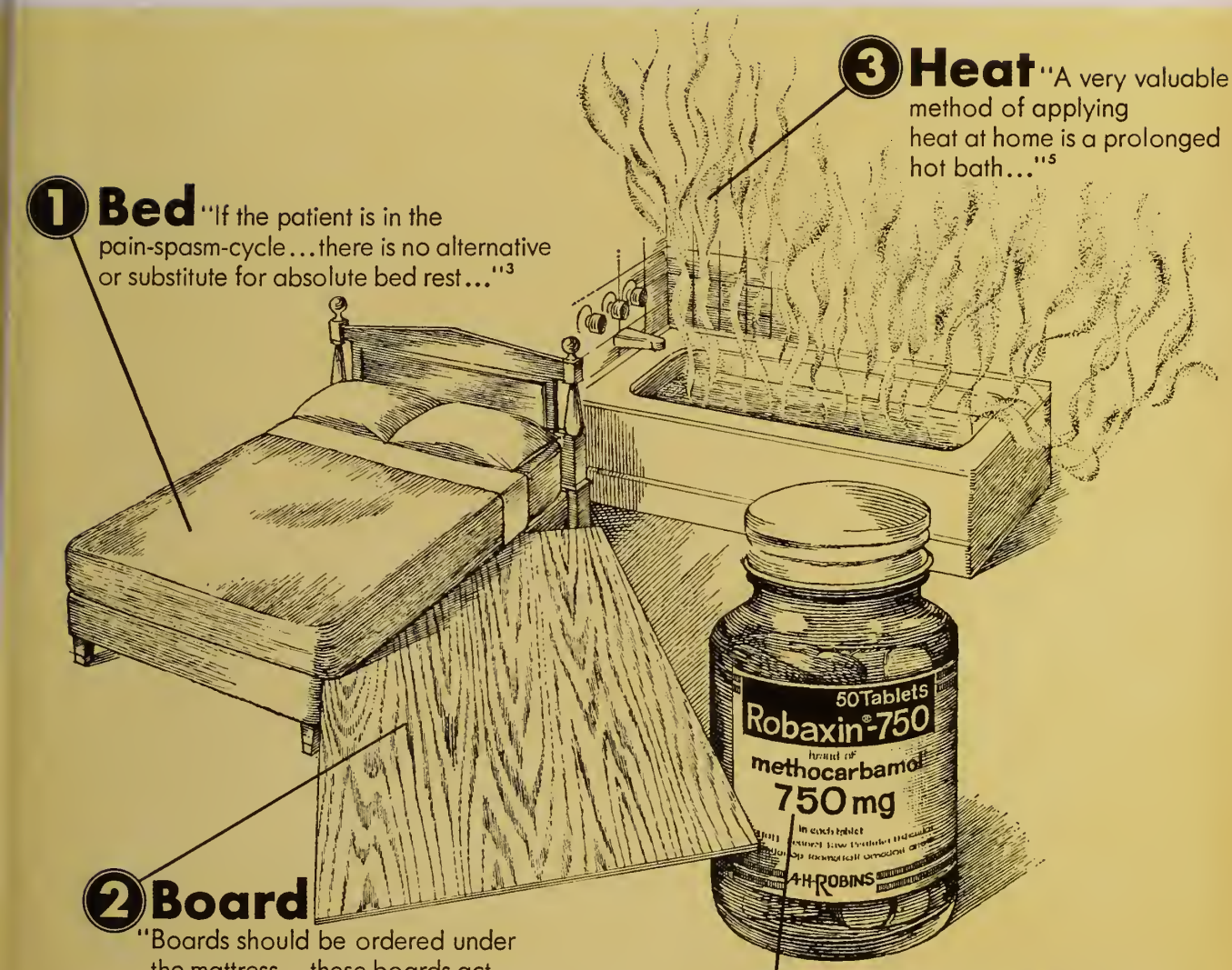
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References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottscholk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dokoto J. Med. 18:26, 1965. (5). Sato-Holl, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. ond Weiss, S.: J. Am. Osteopoth. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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Contraindications: In glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

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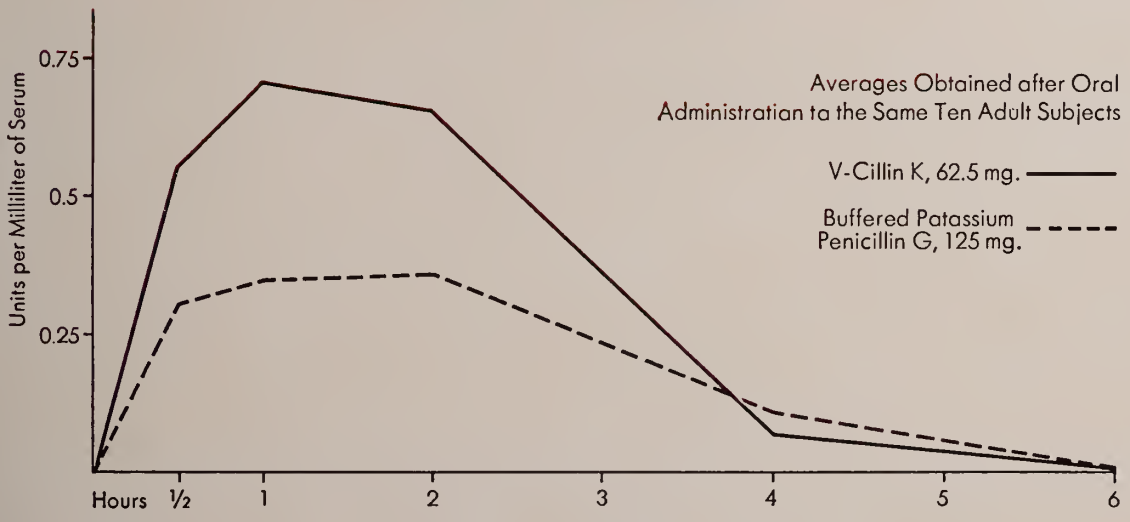
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Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Claxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

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V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with h parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratary stuc (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration sho be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much l common with administration of oral penicillin than with intramuscu forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sigr cant index of sensitization. The following hypersensitivity reactic associated with the use of penicillin have been reported: skin rash ranging from maculopapular eruptions to exfoliative dermatitis; u caria; and reactions resembling serum sickness, including chills, fev edema, arthralgia, and prostration. Severe and often fatal anaphyla has occurred (see Warnings). Hemolytic anemia, leukopenia, thrc bocytopenia, and nephropathy are rarely observed side-effects a are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin Pediatric, the usual dosage ranges from 125 mg. (200,000 units) thr times a day to 500 mg. (800,000 units) every four hours. For infan the daily dosage may be 50 mg. per Kg. of body weight divided in three doses.

Beta-hemolytic streptococcus infections without associated bc teremia may be treated with 200,000 to 400,0000 units three times day. Therapy should be continued for a minimum of ten days to preve development of rheumatic fever and/or other serious complicatiar Dosage for routine streptococcus prophylaxis in patients with a hista of rheumatic fever or congenital heart disease may be 200,000 un once or twice daily. When such patients undergo tonsillectomy, taa extraction, or other minor surgery, the prophylactic dose should b 500,000 units every six hours given two days prior to surgery and f two days postoperatively. If oral medication is not feasible on the dc of surgery, parenteral therapy should be considered. Mild to made ately severe pneumococcus pneumonia has been treated effective with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be give every six to eight hours in conjunction with indicated surgical prac dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours f three doses may be employed; in females, 500 mg. every four hau for six doses are recommended. Refractory infections generally respan to a second treatment three to four days following completion of th first. Treatment of gonorrhea with severe complications should b individualized, with prolonged and intensive treatment. Patients with suspected lesion of syphilis should have a dark-field examination be fore receiving penicillin and monthly serologic tests for a minimum c three months.

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EDITORIALS

Cost Conscious

IN RECENT weeks the rising cost of medical care has received a great deal of attention in the newspapers and other media. This was true before the recent National Medical Cost Conference was held in Washington. Medical care also received attention at the last meeting of the AMA.

It is reported that the cost of a single day's hospital stay increased 10 percent in 1966, and is expected to increase another 9 to 10 percent in 1967. A figure of $61 has been given as the national average for the cost of a single day's stay in the larger hospitals. This figure will certainly go up. Hospital workers' wages account for 63 percent of all hospital expenses and the wage level of these workers will continue to rise if the general economy remains good. Other major elements in the total cost are such items as food and the increasing cost of purchasing and maintaining expensive equipment.

The 300 some participants at the National Medical Cost Conference did not provide any specific recommendations for coping with the problem. Health, Education and Welfare Assistant Secretary Philip R. Lee, M.D., did encourage and advise the participants to get to work on the problems on the local level.

The Federal health programs, Medicare and Medicaid, are caught in the health cost increase. Such programs seem to have a way of turning out to be much more expensive than predicted. With the rising costs the Federal health care outlay has to be increased or else the benefits have to be reduced. It is not likely that benefits once given would be reduced. That would be political surgery of the most painful kind. In fact, there is considerable effort to extend the benefits which again was predictable.

There may be a number of things that could be done to get the most out of the health dollar. Community wide coordination of health facilities in some instances might prevent expensive duplication. Coordinated bulk purchasing of certain supplies might provide a better price for certain items or services.

With the shortage of nurses the concept of progressive patient care within the hospital would offer economy of personnel and there might in addition be a more economical overall operation. This system depends upon grading the nursing care a patient requires and includes such categories as intensive, intermediate, extended and ambulatory units.

Changes in insurance coverage need to be considered. At the present time insurance coverage for the most part emphasizes care in the hospital. Many physicians have had the experience of a patient saying, "If you admit me to the hospital my insurance will pay for it. If you don't, it won't" Greater coverage for outpatient care needs to be developed. Greater coverage to permit the practice of preventive medicine might in the long run save money as well as prolong lives.

Physicians should assume the leadership in the health field and to do this they will have to become cost conscious. The House of Delegates of the AMA has adopted the overall policy that "physicians continue to do everything possible to help the public conserve its health care dollars."

WALTER S. COE, M.D.

There Is A Need

GRADUATE education is expensive, and it is depressing to find that those who wish to pursue the study of medicine have only one-fourth the opportunity to obtain help in non-refundable grants or scholarships as those in other fields. In 1963 only 17% of all medical students in the United States received scholarships, which averaged only $585, whereas 80% of life science graduate students received grants averaging $2700.

A fascinating corollary is that almost six times as many medical students (29%) as people in general (5%) come from families with annual incomes of $15,000 or more. High ability students do come from all socio-economic levels. To illustrate: Only 29% of National Merit Scholars in 1960 came from families with incomes of more than $10,000, while 21% came from families with incomes less than $5,000.

Graduate students in the arts and sciences, medicine and other professional schools are derived from a common and limited pool of capable college students. It seems quite obvious that many very talented individuals must turn to other fields rather than medicine when they are confronted by the financial limbo inherent, not only in obtaining a medical degree, but also in the years of training which follow.

More doctors are needed, but little seems to be done to help or encourage the outstanding student who wishes to study medicine. It is true that various loans are available, but to a limited extent, and even the most generous of these may impose a discouraging amount of indebtedness.

In Kentucky the problem is most acute. This state is not wealthy, nor are her people. Many of our prospective high quality medical students need help, and our medical schools have no endowments for which significant scholarships may be offered. For this reason, some of these individuals are totally lost to medicine and others go to schools of medicine which are able to offer them valuable scholarship assistance outside the state. The presence of these students, many of them quite superior, in our own fine schools would be inevitably stimulating to the schools and assure a brighter medical future for Kentucky.

There is a need, not only for a greater awareness of the problem, but for positive action on the part of individual physicians, county medical societies, and the Kentucky Medical Association. Endowments for non-refundable grants should be promoted, established, sustained and subscribed. Let us abolish this need.

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Annual Meeting Section

KMA OFFICERS 1966 — 1967



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PRESIDENT-ELECT
George F. Brockman, M.D.
Greenville, Ky.

The installation of Doctor Brockman as president of the Kentucky Medical Association will take place Wednesday evening, September 27, during the 1967 Annual Meeting in Louisville.

Doctor Brockman, after serving three years as vice-speaker of the KMA House of Delegates and one year as speaker, was named president-elect in 1966. He was the KMA delegate to the AMA in 1961. He has served on many KMA committees and more recently as chairman of the Building Committee and the Advisory Committee to the Editor of *The Journal.*

A native of Louisville, Doctor Brockman graduated from the University of Louisville School of Medicine in 1935. He served his internship at Louisville General Hospital and completed his residency at Hazelwood Sanitorium. He received his M.S. degree from the University of Kentucky in 1939. A commissioned officer in the U.S. Public Health Service Reserve, Doctor Brockman requested military duty and served in the Aleutians and North Pacific from 1943 to 1945.

Following training in radiology at Cook County Hospital, Chicago, he entered private practice in Greenville, where he established the Greenville Cancer Clinic with Gaithel L. Simpson, M.D. As the first American Cancer Society Clinic in a rural area, it received the Kentucky Cancer Society Medal for 1955.

Doctor Brockman has served as secretary of the Muhlenberg County Medical Society and the medical staff of the Muhlenberg Community Hospital since 1947. He was on the Muhlenberg County Board of Health from 1947 through 1964.

In addition to his participation in medical affairs, Doctor Brockman is active in his community. A longtime member of the Greenville and Kentucky Chambers of Commerce, he was a founder of the Greenville Industrial Development Foundation and the Muhlenberg County Chamber of Commerce. He was president of the Greenville Kiwanis Club in 1962.

Doctor Brockman spent two months in South Viet Nam in 1965 helping to initiate the Volunteer Physicians for Viet Nam program of the AMA. This program provides opportunities for civilian practictioners to serve in Viet Nam for two months on a voluntary basis to provide teaching and medical care. He returned to Viet Nam for two months in 1966 to observe the program's progress.

Doctor Brockman's excellent record of participation in the activities of medicine and the community and his personal qualities of leadership and dedication to his profession make him an outstanding choice as president-elect.

VICE PRESIDENT, CENTRAL
Roy H. Moore, Jr., M.D., Louisville

A 1939 graduate of the University of Louisville School of Medicine, Doctor Moore is a past president of the Jefferson County Medical Society and president of the St. Joseph Infirmary staff. He served as Commanding Officer of the 326 Airborne Medical Company of the U.S. Army and was decorated with the Purple Heart, Bronze Star with Oak Leaf Cluster and four Battle Stars. Doctor Moore entered practice as a surgeon in Louisville in 1949 and was a clinical associate in surgery at the University of Louisville School of Medicine from 1942 to 1966. In 1949 he was made a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. He is a member of the Louisville and Kentucky Surgical Societies and of the Louisville Chamber of Commerce.

VICE PRESIDENT, EASTERN
James C. Cantrill, M.D., Georgetown

Doctor Cantrill has served KMA as Sixth District Key Man and is Chairman for State Affairs of the Council on Legislative Activities. A 1950 graduate of the University of Virginia College of Medicine, he has been in general practice at Georgetown since 1954. Doctor Cantrill is a member of the Scott County Board of Health and secretary-treasurer of the Scott County Medical Society. He has also served as president of the latter organization and as its delegate to KMA. He is a former member of the Rotary Club and has been a delegate for a number of years to the National Convention of the Episcopal Church.

VICE PRESIDENT, WESTERN
James A. Harris, M.D., Paducah

The late Doctor Harris, a diplomate of the American Board of Urology, graduated from Duke University Medical School in 1950 and completed his internship and residency training at the University of Virginia. He served in the U.S. Marine Corps from 1941 to 1946 and held the rank of colonel in the Marine Reserve. Doctor Harris practiced at Paducah from 1959 until his death in January of this year. He had been director of the Paducah Red Cross, president of the Paducah Rotary Club and a member of the Kentucky Hospital Board of Accreditation.

KMA Secretary and Treasurer

SECRETARY

Henry B. Asman, M.D., Louisville



A former vice-president of KMA (1961-63), Doctor Asman has served the Association as its secretary since 1963. He graduated from the University of Louisville School of Medicine in 1936 and started his practice of coloproctology in Louisville in 1939. From 1942 to 1946 he served in the U.S. Army Medical Corps. Doctor Asman, a past president of the Kentucky Division of the American Cancer Society, is a fellow of the American College of Surgeons and the Southeastern Surgical Congress. He was a clinical associate in surgery at the University of Louisville School of Medicine from 1938 to 1958.

TREASURER

Keith P. Smith, M.D., Corbin



Doctor Smith has served KMA as a trustee (1957-1963), Chairman of the Board (1962-63), vice-president, (1951-52) and treasurer since 1963. A 1936 graduate of the University of Louisville School of Medicine, Doctor Smith is a former president and vice-president of the Kentucky Academy of General Practice. He served with the U.S. Air Force during World War II and was elected first Chief of Staff of the Corbin Municipal Hospital. In addition to his participation in KMA activities, Doctor Smith is a Kiwanian and active in community affairs.

KMA Journal Editors

EDITOR

Walter S. Coe, M.D., Louisville



Before assuming his position as editor of *The Journal* in 1966, Doctor Coe had served as associate editor since 1962 and as book reveiw editor for many years before. Doctor Coe graduated from the University of Louisville School of Medicine in 1943 where he is now an associate clinical professor of medicine. He has served as director and president of the Kentucky Heart Association, and he is a past president of the Louisville and Jefferson County Heart Association and the Kentucky Society of Internal Medicine.

ASSISTANT EDITOR

Walter I. Hume, Jr., M.D., Louisville



Appointed as assistant editor of *The Journal* this year, Doctor Hume has been active in the Council on Medical Education for several years and chairman during the past year. He had previously been editor of the *Bulletin* of the Jefferson County Medical Society. A 1949 graduate of Harvard Medical School, Doctor Hume has been practicing in Louisville for 10 years. He is an assistant clinical professor of surgery at the University of Louisville School of Medicine.

ASSOCIATE EDITOR

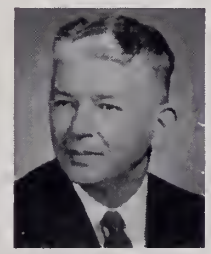
Sam A. Overstreet, M.D., Louisville



In addition to his position as associate editor of *The Journal,* Doctor Overstreet assumed the responsibilities of scientific editor after the death of Jack L. Chumley, M.D., in March. Doctor Overstreet had previously served as editor of *The Journal* for eight years. He was president of KMA during its Centennial in 1950-51 and has served as speaker of the House of Delegates. He was recently appointed by the Governor to his second term as a member of the State Board of Health, following nomination by KMA. Doctor Overstreet received his M.D. degree in 1923 from the University of Louisville School of Medicine.

AMA Delegate

J. Thomas Giannini, M.D., Louisville



Doctor Giannini has served KMA as a delegate to AMA since 1963 and had previously served as an alternate delegate to AMA and as chairman of the Scientific Exhibits Committee. Before that time he was a member of the KMA House of Delegates representing the Jefferson County Medical Society. Doctor Giannini graduated from the University of Louisville School of Medicine in 1938 and served in the U.S. Navy Medical Corps from 1942-54. He is a Fellow of the American Society of Plastic and Reconstructive Surgeons and limits his practice to plastic and reconstructive surgery.

AMA Delegates

John C. Quertermous, M.D., Murray



Doctor Quertermous, chairman for national affairs of the KMA Council on Legislative Activities, was recently elected chairman of the KEMPAC Board of Directors. He has served as a delegate to the AMA since 1963 and had previously served as an alternate delegate. A 1942 graduate of the University of Louisville School of Medicine, Doctor Quertermous has practiced as an internist at Murray since 1950. He is a past president of the Calloway County Medical Society and has served KMA as a member of the Committee on Aging and the Committee on Postgraduate Medical Education.

Charles C. Rutledge, M.D., Hazard



A former alternate delegate to AMA, Doctor Rutledge was elected a delegate in 1965. He was a Councilor of KMA for three years and a member of the Scientific Assembly Committee for five years. He has also served KMA as a district keyman and as district chairman for KEMPAC for four years. Doctor Rutledge graduated from the University of Louisville School of Medicine in 1946 and has practiced since 1955 in Hazard, having previously practiced in Pikeville. He is a past president of the Pike and Perry County Medical Societies and a past councilor of the Kentucky Chapter, American College of Surgeons.

New Trustees

George A. Sehlinger, M.D., Louisville

A 1940 graduate of the University of Louisville School of Medicine, Doctor Sehlinger, a urologist, has practiced in Louisville since 1948. From 1942 to 1945 he served in the U.S. Army Medical Corps, spending part of that time in the Second Auxiliary Surgical Group in North Africa, Sicily and Italy. Doctor Sehlinger, a diplomate of the American Board of Urology and a fellow of the American College of Surgeons, is an assistant professor of urology at the University of Louisville School of Medicine.

Leroy C. Hess, M.D., Florence

Doctor Hess, a general practitioner, graduated from the University of Louisville School of Medicine in 1956 and completed his internship at St. Elizabeth Hospital, Covington, where he now teaches in the School of Nursing. A member of the American Academy of General Practice, the Kentucky Academy of General Practice and an associate of the Cincinnati Academy of Medicine, Doctor Hess was treasurer of the Boone County Medical Society in 1966.

Douglas H. Jenkins, M.D., Richmond

A 1949 graduate of the University of Louisville School of Medicine, Doctor Jenkins, a surgeon, completed his internship and residency at Good Samaritan Hospital, Lexington. A U.S. Navy aviator from 1940 to 1945, Doctor Jenkins was awarded the air medal, Presidential Unit Citation and Distinguished Flying Cross. He is a member of the Kentucky Surgical Society and the Southeastern Surgical Congress, a fellow of the American College of Surgeons and a diplomate of the American Board of Surgery.

Ballard W. Cassady, M.D., Pikeville

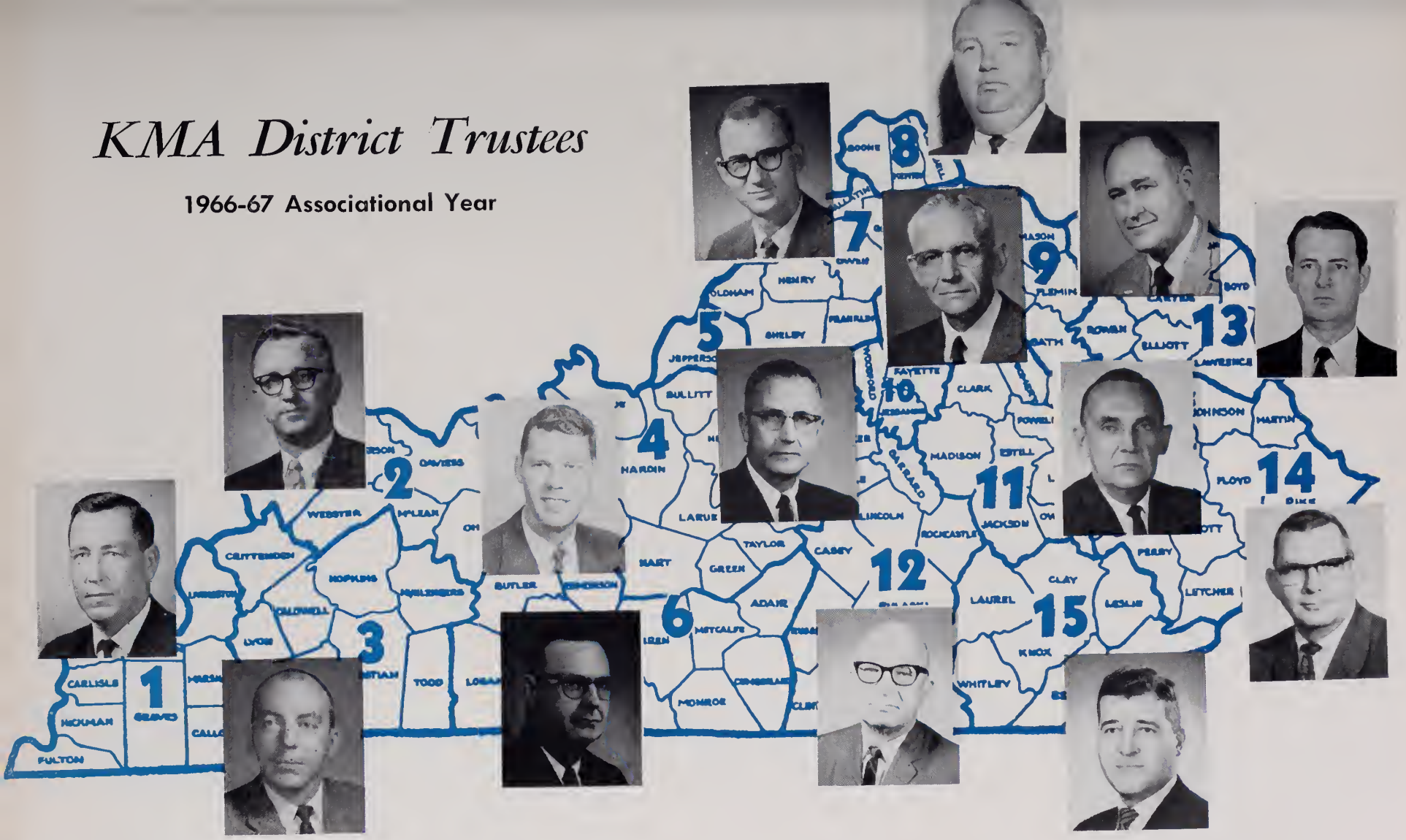
Doctor Cassady, a surgeon, graduated from the University of Louisville School of Medicine in 1946 and interned at Good Samaritan Hospital, Lexington. His residency training at St. Joseph's Hospital, Lexington, where he was chief resident in 1953-1954, was interrupted by three years of service in the U.S. Army from which he was discharged in 1951 with the rank of major. Doctor Cassady, a 1956 fellow of the American College of Surgeons, was certified by the American Board of Surgery in 1955. He is now on the staff of the Pikeville Methodist Hospital.

Election of Trustees

The House of Delegates will elect five district trustees at its second session, Wednesday, September 27. The trustees to be elected will be nominated by the delegates of their respective districts at a meeting immediately following the first session of the House on Monday, September 25. The committee will report its nominees at the close of the first scientific session on Tuesday, September 26. At the final meeting of the House, Wednesday evening, September 27, nominations may be made from the floor. All nominations are considered and acted upon by the delegates at this final session. Districts electing new trustees for three-year terms are: **Second District** (incumbent, W. Gerald Edds, M.D., Calhoun); **Seventh District** (incumbent, Donald Chatham, M.D., Shelbyville); **Ninth District** (incumbent, Mitchel B. Denham, M.D., Maysville); **Tenth District** (incumbent, Douglas E. Scott, M.D., Lexington); and **Thirteenth District** (incumbent, Walter L. Cawood, M.D., Ashland). Doctors Edds, Chatham and Cawood have served only one full term and are eligible for re-election.

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* *Member of the Executive Committee*

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SPEAKER
Richard F. Greathouse, M.D., Louisville



Before he became speaker of the KMA House of Delegates in 1966, Doctor Greathouse served for one year as vice-speaker and has served as delegate of KMA from the Jefferson County Medical Cociety. He was secretary-treasurer of KEMPAC from 1965 to 1967. Doctor Greathouse, a pediatrician, graduated from the University of Louisville School of Medicine in 1951 and has practiced in Louisville since 1954. A past president of the Louisville Pediatric Society, he is an assistant clinical professor of pediatrics at the University of Louisville Schools of Medicine and Dentistry.

VICE-SPEAKER
Carl C. Cooper, M.D., Bedford



A past vice president of KMA and former alternate delegate to the AMA, Doctor Cooper, a general practitioner, graduated from the University of Louisville School of Medicine in 1952. He has also served KMA as chairman of the Senior Day Committee, as a member of the Council on Communications and Public Service and as representative on the Kentucky Health Council. Doctor Cooper is a past vice-president of the Kentucky Academy of General Practice and a member of the American Academy of General Practice. He is active in local community affairs.

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WOODFORD

Nominating Committee To Hold Open Meeting Monday, Sept. 25

The KMA Nominating Committee will hold an open meeting following the close of the first session of the House of Delegates Monday morning, September 25, at the alcove in the far end of the Terrace Room. Members may confer with the Committee at that time.

The Committee's final recommendations will be reported at the end of the first scientific session Tuesday morning, September 26. Other nominations may be made from the floor at the meeting of the House of Delegates Wednesday evening, September 27. At the close of the session, the House will vote on the nominees.

Members of the Nominating Committee are Chairman Robert L. McClendon, M.D., Louisville; John S. Ashworth, M.D., Ashland; Harold B. Barton, M.D., Corbin; Andrew H. Moore, M.D., Lexington; and W. Vinson Pierce, M.D., Covington.

Reference Committee Activity

At the first meeting of the KMA House of Delegates at 9 a.m. Monday, September 25, Speaker Richard F. Greathouse, M.D., Louisville, will refer **all officers' and committees' reports and resolutions** to one of seven reference committees. Members of the reference committees will meet for briefing sessions at 12:30 p.m. Monday in Parlor B, Kentucky Hotel. **Any KMA member wishing to testify on any resolution or report is urged to be present at 2 p.m. on Monday, September 25, when reference committees will meet on the mezzanine floor of the Kentucky Hotel.** These open sessions will last at least an hour in order to permit all who wish to speak to be heard. Following the open hearings, the committees will go into executive sessions to study the reports, review the testimony and write its report to the House.

The committees' recommendations will be made **at the final session of the House on Wednesday night, September 27,** in the Terrace Room of the Kentucky Hotel. The reference committees appointed by Doctor Greathouse to serve during the 1967 session are listed below.

1967 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1
Officers and Board of Trustees

Parlor A

C. Melvin Bernhard, M.D., Louisville, Chairman
John F. Berry, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hyden
Thomas L. Heavern, M.D., Highland Heights
R. J. Phillips, M.D., Owensboro

REFERENCE COMMITTEE NO. 2
Scientific Assembly and Medical Education

Room 204

Eugene H. Conner, M.D., Louisville, Chairman
C. C. Lowry, M.D., Murray
R. J. Salisbury, M.D., Mt. Sterling
Ralph G. Thomas, M.D., Leitchfield
J. Sankey Williams, M.D., Nicholasville

REFERENCE COMMITTEE NO. 3
Legislative Activities

Parlor B

David A. Hull, M.D., Lexington, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
Clyde T. Moore, M.D., Fern Creek
W. Faxon Payne, M.D., Hopkinsville

REFERENCE COMMITTEE NO. 4
Public Service and Medical Services

Room 203

W. Fielding Rubel, M.D., Louisville, Chairman
W. E. Becknell, M.D., Manchester
Kenneth M. Eblen, M.D., Henderson
Robert Robbins, M.D., Greenville
James B. Tolliver, M.D., Whitesburg

REFERENCE COMMITTEE NO. 5
Governmental Medical Service

Parlor D

Andrew M. Moore, M.D., Lexington, Chairman
James L. Ferrell, M.D., Paris
Walter Johnson, M.D., Paducah
Robert E. Norsworthy, M.D., Hartford
William M. Wyatt, M.D., Somerset

REFERENCE COMMITTEE NO. 6
Constitution and Bylaws; Special Committees

Parlor C

W. Vinson Pierce, M.D., Covington, Chairman
John M. Baird, M.D., Danville
N. Lewis Bosworth, M.D., Lexington
Robert L. McClendon, M.D., Louisville
Dixie Snider, M.D., Springfield

REFERENCE COMMITTEE NO. 7
Miscellaneous

Room 205

Harvey A. Page, M.D., Pikeville, Chairman
Donald L. Graves, M.D., Frenchburg
James G. Sills, M.D., Hardinsburg
Loman C. Trover, M.D., Madisonville
Donald Varga, M.D., Louisville



The Kentucky Hotel
KMA Annual Meeting Headquarters

Annual Meeting Special Features

THE HOUSE OF DELEGATES, the policy-making body of KMA, will hold two sessions during the Annual Meeting—9 a.m., Monday, September 25, and 7 p.m. Wednesday, September 27. Officiers will be elected at the second session. Both meetings will be held in the Terrace Room of the Kentucky Hotel.

SCIENTIFIC SESSIONS will feature prominent guest speakers and a "Transatlantic CPC" session on "Gastrointestinal Hemorrhage." Themes of the program are "Trauma," "Allergy," "Therapeutic Abortions" and "Birth Control." A "What's New" Symposium has been added this year. Scientific sessions will be held on September 26, 27 and 28.

THE PRESIDENT'S LUNCHEON on September 27 will present guest speaker Nicholas P. Dallis, M.D., Scottsdale, Arizona, author of the comic strips "Rex Morgan, M.D., "Judge Parker," and "Apartment 3-G." His topic will be "Life Among the Comic Strip Heroes and Heroines." The Distinguished Service Medal, the Outstanding General Practitioner Award and the R. Haynes Barr Award will be presented at the luncheon.

SIXTEEN SPECIALTY GROUPS will hold their meetings as part of the KMA Annual Meeting. Seven specialty groups will meet Tuesday afternoon, September 26, and nine will meet on Thursday afternoon, September 28. General sessions are not planned at these times, and all KMA members are invited to attend the specialty group meetings.

SEVENTY-FIVE TECHNICAL EXHIBITS will be on display at Convention Center during the meeting. They will offer an opportunity for busy physicians to see the latest developments in pharmaceuticals, equipment, instruments and medical literature. Thirty-minute intermissions have been scheduled throughout the general and specialty group sessions allowing time for visits to the exhibits.

ALUMNI REUNIONS will be held by five-year classes of the University of Louisville School of Medicine. A special feature of this year's traditional class reunions will be a ride on the Belle of Louisville. A tour of the Medical Center is also planned.

OFFICIAL CALL

KMA Annual Meeting

To the officers and members of the component county medical societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KMA will convene, at the Convention Center, Louisville, on Tuesday, Wednesday, and Thursday, September 26, 27, and 28. The first general session will be called to order at 8:50 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m., Monday, September 25. The second regular business session will begin at 7 p.m., Wednesday, September 27. Dinner will be served to the delegates preceding the session at 6 p.m. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

Registration

The registration desk will open at the Terrace Room of the Kentucky Hotel at 8 a.m. on Monday, September 25 and at 5:30 p.m., Wednesday, September 27. It will be open in the technical exhibit hall of the Convention Center from 8 a.m. to 5 p.m. on Tuesday, September 26; Wednesday, September 27; and Thursday, September 28.

House Of Delegates To Elect Officers At Final Session

The House of Delegates will elect the KMA officers for the 1967-68 Associational year at the final session Wednesday evening, September 27. The officers to be selected are:

President-Elect	**(Central)**	**One Year**
Vice-Presidents	**(Central)**	**One Year**
	(Eastern)	**One Year**
	(Western)	**One Year**

***AMA Delegates for term—Jan 1, 1968 to Dec. 31, 1969 (incumbents, John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard)**

***AMA Alternate Delegates for term—Jan 1, 1968-Dec. 31, 1969 (incumbents, William W. Hall, M.D., Owensboro, and David B. Stevens, M.D., Lexington)**

Five new trustees will be elected for regular three-year terms. Districts which will elect trustees are:

***Second District (incumbent, W. Gerald Edds, M.D., Calhoun)**

***Seventh District (incumbent, Donald Chatham, M.D., Shelbyville)**

Ninth District (incumbent, Mitchel B. Denham, M.D., Maysville)

Tenth District (incumbent, Douglas E. Scott, M.D., Lexington)

***Thirteenth District (incumbent, Walter L. Cawood, M.D., Ashland)**

Doctor Denham and Doctor Scott have served two full terms as district trustees and therefore are not eligible to succeed themselves.

**Eligible for re-election*

Transatlantic CPC, New Symposium To Headline 1967 Meeting

A Transatlantic CPC on "Gastrointestinal Hemorrhage" and a symposium on new developments in various medical specialties will headline the program of the 1967 KMA Annual Meeting, according to Roderick McDonald, M.D., Louisville, chairman of the program committee.

The Transatlantic CPC will feature four members of the Royal Commonwealth of the Postgraduate Institute of England and four KMA members. It is scheduled for Wednesday afternoon, September 27 at 2 p.m.

An innovation this year is a "What's New Symposium"—a series of brief sessions by specialists discussing the latest developments in their respective fields. Scheduled for Wednesday morning, September 27, the symposium will have as participants, Beverly T. Towery, M.D., Louisville, internal medicine; John Greene, M.D., Lexington, obstetrics and gynecology; Vernon L. James, Jr., M.D., Lexington, pediatrics; Donald R. Kmetz, M.D., Louisville, pathology; and Warren M. Cox, M.D., Louisville, psychiatry.

Other topics to be covered at the 1967 meeting include trauma, allergy, organ transplants, therapeutic abortions, and birth control.

RESERVE HOTEL SPACE NOW

You are urged to make your hotel reservations for the KMA Annual Meeting, September 26-28, as soon as possible by KMA President Robert E. Pennington, M.D., London.

Excellent accommodations are available at hotels and motels in downtown Louisville or surrounding areas within easy access of convention facilities. It is suggested that you make reservations now to be sure of rooms.

Dr. Brockman To Talk On Vietnam At Woman's Auxiliary Luncheon

George F. Brockman, M.D., Greenville, KMA president-elect, will give an illustrated lecture on "Viet Nam—U.S. Doctors Are There" at the annual luncheon of the Woman's Auxiliary to KMA at 12:30 p.m., Tuesday, September 26, in the Terrace Room of the Kentucky Hotel.

Doctor Brockman has served in South Viet Nam with the Volunteer Physician Program sponsored by the AMA and the U.S. State Department. His work there has been featured on several television programs this year.

Mrs. Raymond Jones, president of the Woman's Auxiliary, urges all members of the Auxiliary to attend and to bring their husbands as guests to the luncheon.

Past presidents, members-at-large and distinguished guests will be honored at the luncheon, and membership awards will be presented by Mrs. Charles C. Kissinger, president-elect of the Auxiliary.



Comic Strip Author to Speak at President's Luncheon

"Life Among the Comic Strip Heroes and Heroines", an illustrated talk by Nicholas P. Dallis, M.D., Scottsdale, Arizona, will highlight the 1967 KMA President's Luncheon at the Kentucky Hotel on Wednesday, September 27.


Doctor Dallis

Doctor Dallis, the author of three nationally known comic strips, including "Rex Morgan, M.D.", will be accompanied to Kentucky by one of his staff artists who will help illustrate his talk. His career as a comic strip artist started in 1948 when he created "Rex Morgan, M.D." Four years later he introduced "Judge Parker" and in 1952 "Apartment 3-G" was started.

A graduate of Temple University School of Medicine in 1938, Doctor Dallis is a former director of the Toledo (Ohio) Mental Health Clinic, a diplomate of the American Board of Psychiatry and Neurology and a Fellow of the American College of Psychiatrists. He practiced psychiatry in Toledo for 14 years before discontinuing his private practive in 1959 to devote full time to the authorship of his comic strips.

Doctor Dallis will speak following the luncheon which is scheduled for 11:50 a.m. in the Flag Room of the Kentucky Hotel.

Three Top KMA Awards To Be Given During President's Luncheon

A traditional feature of the Annual Meeting, presentation of KMA's three top awards, will take place during the President's Luncheon at noon, Wednesday, September 27, according to Richard F. Grise, M.D., Bowling Green, chairman of the Awards Committee.

The Distinguished Service Medal, the Outstanding General Practitioner Award and the R. Haynes Barr Award will be given at the luncheon. The 1966 recipients were W. Vinson Pierce, M.D., Covington, Distinguished Service Medal; John C. Baker, M.D., Berea, Outstanding General Practitioner Award; and Archibald Cochran, Louisville, R. Haynes Barr Award for an outstanding contribution to medical progress by a layman.

Nominations for the first two awards will be presented by the Awards Committee to the House of

Delegates at its first session on Monday, September 25. Other nominations may be made from the floor. The Awards Committee names the recipient of the Barr Award.

The Awards Committee members serving with Doctor Grise are William A. Blodgett, M.D., Louisville; Frank L. Duncan, M.D., Monticello; C. Wayne Franz, M.D., Ashland; and Joseph Keith, Jr., M.D., Lexington.

Orientation Course To Be Offered For New KMA Members Sept. 25

Approximately 120 new KMA members will have an opportunity to take the Fifth KMA Orientation Course, which will be held in the Mirror Room of the Kentucky Hotel on Monday, September 25, just prior to the opening of the 1967 KMA Annual Meeting.

The members of the KMA Council on Communications and Public Service has spent much time in preparing an outstanding program designed to better equip the new KMA member in meeting present-day responsibilities as a citizen and as a physician. The informative and fast-moving session will begin promptly at 8:30 a.m., following registration at 8:00 a.m., and will adjourn by 12:30 p.m.

Letters of invitation are being sent to those KMA members who have joined the Association during the past two years and have not as yet attended an orientation program. Any KMA member, whether he receives an invitation or not, is most welcome to attend the course. Following is the program to be presented at the Fifth Course on Monday, September 25.

KMA ORIENTATION PROGRAM

Moderator
N. Lewis Bosworth, M.D., Lexington

8:00 a.m. **Registration**

8:30 a.m. **Welcome and Introduction**
Robert E. Pennington, M.D., London
KMA President

8:35 a.m. **The Wife's Role in Organized Medicine**
Mrs. Raymond Jones, Louisville
President, Woman's Auxiliary to KMA

Structure-Function-Policies in Organized Medicine

8:50 a.m. **"County Medical Society"**
Walter Johnson, M. D., Paducah
President
McCracken County Medical Society

9:05 a.m. **"Kentucky Medical Association"**
Henry B. Asman, M. D., Louisville
KMA Secretary

9:20 a.m. **"American Medical Association"**
Robert C. Long, M. D., Louisville
Member, AMA Board of Trustees

9:35 a.m. **"Community Relations"**
Charles Rutledge, M. D., Hazard..
Delegate to AMA

9:55 a.m. **"Health Insurance (Blue Cross-Blue Shield)"**
Avil McKinney, Louisville
Director of External Operations, Blue Cross-Blue Shield

10:10 a.m. **"Health Insurance (Commercial)"**
George M. Paterson, Louisville
District Group Claims Manager
New York Life Insurance Company

10:25 a.m. **COFFEE BREAK**

10:40 a.m. **Cults**
David B. Stevens, M. D., Lexington
Chairman, KMA Cults Committee

10:55 a.m. **Medical Ethics**
Clyde C. Sparks, M. D., Ashland
KMA Past President

11:15 a.m. **Medico-Legal Aspects**
E. Gaines Davis, Jr., Frankfort
KMA Legal Counsel

11:35 a.m. **Medico-Press Relations**
William Gladden, Louisville
Director of Public Relations, WAVE, Inc.

11:50 a.m. **The National Scene for Medical Legislation**
John C. Quertermous, M. D., Murray
Chairman for National Affairs
KMA Council on Legislative Activities

12:05 p.m. **State Legislation and the KMA Key Man System**
Fred Rainey, M.D., Elizabethtown
KMA Council on Legislative Activities

12:15 p.m. **The Physicians Role in Legislation and Politics**
Hoyt D. Gardner, M. D., Louisville
Secretary-Treasurer
American Medical Political Action Committee

Emergency Number To Be 584-2201 During Annual Meeting

Your home, office or hospital may contact you during your attendance at the KMA Annual Meeting in Louisville by calling the number 584-2201 (Area Code 502). This is the number of the Message Center which will be staffed by trained employees of Southern Bell.

The Message Center, a convenient and efficient location for the transfer of messages, will be situated in the center of the Technical Exhibit Hall at Convention Center.

Individual physicians will not be paged, due to the arrangements of facilities for the meetings.

Only emergency calls will be posted on the blackboards in the entrance lobby of Convention Center and the Scientific Assembly Hall. You are asked to check frequently at the message center where *all messages* will be on file.

You may locate other physicians through the message center by calling 584-2201 and asking that your messages be delivered.

Phone number of the Kentucky Hotel is 587-1181. Your calls should be directed to the Terrace Room if you are attending the meetings of the House of Delegates (Monday, September 25 beginning at 9 a.m. and Wednesday evening, September 27, beginning at 6:30 p.m.)

You are urged by Robert E. Pennington, M.D., London, KMA president, to make use of the message center to receive all calls and messages quickly.

1967 Annual Meeting Program Summary

The Kentucky Medical Association

September 24, 25, 26, 27, and 28

Louisville

SUNDAY, SEPTEMBER 24

12:30 p.m. Luncheon Meeting, KMA Board of Trustees ..... Parlor A, Kentucky Hotel
6:30 p.m. Dinner Meeting, Board of Directors, Ky. Physicians Mutual ..... Ship Room, Kentucky Hotel

MONDAY, SEPTEMBER 25

8:30 a.m. Orientation Program, New KMA Members ..... Mirror Room, Kentucky Hotel
9:00 a.m. First Meeting, KMA House of Delegates ..... Terrace Room, Kentucky Hotel
12:30 p.m. Luncheon for Reference Committee Chairman ..... Room 317, Kentucky Hotel
2:00 p.m. Reference Committee Meetings ..... Parlors A, B, C. D—Rooms 203, 4 & 5, Kentucky Hotel
6:00 p.m. KEMPAC Reception, Banquet and Seminar ..... Flag Room, Kentucky Hotel

TUESDAY, SEPTEMBER 26

9:00 a.m. Registration ..... Technical Exhibit Hall, Convention Center
8:50 a.m. Opening Ceremonies ..... Scientific Assembly Hall, Convention Center
9:00 a.m. First Scientific Session ..... Scientific Assembly Hall, Convention Center
2:00 p.m. Specialty Group Sessions, Convention Center *(Seven Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session at this time. See pages 792-794 in program.)*

WEDNESDAY, SEPTEMBER 27

9:00 a.m. Second Scientific Session ..... Scientific Assembly Hall, Convention Center
11:50 a.m. President's Luncheon ..... Flag Room, Kentucky Hotel
2:00 p.m. Third Scientific Session and Transatlantic CPC ..... Scientific Assembly Hall, Convention Center
5:00 p.m. Meeting, Board of Trustees ..... Parlor B—Dinner at 6:00, Parlor A, Kentucky Hotel
6:00 p.m. Subscription Dinner and Meeting, House of Delegates ..... Terrace Room, Kentucky Hotel

THURSDAY, SEPTEMBER 28

9:00 a.m. Fourth Scientific Session ..... Scientific Assembly Hall, Convention Center
12:00 noon Board of Trustees Luncheon and Afternoon Meeting ..... Parlor A, Kentucky Hotel
2:00 p.m. Specialty Group Sessions, Convention Center *(Nine Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session. See pages 796 & 797 in program.)*

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting Scientific and Technical Exhibits.

(Full Scientific Program Starts on page 792)

The Kentucky Medical Association
SCIENTIFIC PROGRAM
William Hudson Wathen Memorial Meeting
Convention Center, Louisville

TUESDAY, SEPTEMBER 26
MORNING SESSION

General Session

Robert E. Pennington, M.D., London, KMA President, Presiding

Theme—"Trauma"

8:50 **Opening Ceremonies**
Welcome—Walter S. Coe, M.D., Louisville
Invocation—The Rev. Dr. C. Earl Leininger, Pastor, Davis Memorial Baptist Church, Louisville

9:00 **"Internal Derangement of the Knee**
Theodore A. Fox, M.D., Chicago, Ill.

9:20 **"Oral-Facial Trauma"**
William C. Kranz, D.M.D., Lexington

9:40 **"Trauma to the Chest"**
John Rankin, M.D., Madison, Wisc.

10:00 **Intermission—Visit Exhibits**

10:30 **President's Address**
Robert E. Pennington, M.D.

10:50 **"Genitourinary Trauma"**
James Glenn, M.D., Durham, N.C.

11:10 **"Aerospace Medicine: A New Working Environment for Man"**
Walter W. Kemmerer, M.D., Houston, Texas

11:30 **"Oxygen Delivery in Shock"**
Peter Safar, M.D., Pittsburgh, Pa.

TUESDAY, SEPTEMBER 26
AFTERNOON SESSION

Specialty Group Meetings

(Seven Specialty Groups will meet on Tuesday afternoon. There will be no General Scientific Session at that time. All KMA members are cordially invited to attend these meetings.)

Kentucky Society of Anesthesiologists
Room 204—Convention Center

2:00 **"Effect of Anesthetics on Immune Response"**
Daniel Wingard, M.D., Lexington

2:30 **(To be announced)**
Peter Safar, M.D., Pittsburgh, Pa.

3:00 **Intermission-Visit Exhibits**

3:30 **"A Survey of Current Anesthetic Practice in Kentucky"**
William E. Hopkins, M.D., Louisville

3:50 **Business Meeting, followed by cocktail party**

THEODORE A. FOX, M.D.
Chicago, Ill.



Associate professor, orthopoedic surgery, R & E Hospitals, University of Illinois College of Medicine. Attending orthopoedic surgeon, Illinois Mosonic Hospitol. Orthopoedic surgeon, Chicogo Beors Football Club. M.D., 1937, Rush Medicol College, University of Chicogo. Choirmon, Subcommittee on Athletic Injuries of the Chicogo Committee on Troumo, Americon College of Surgeons. Editor, "Monuol of Orthopaedics Surgery," Americon Orthopoedic Associotion. Diplomote, Americon Boord of Orthopoedic Surgery. Member, Americon Acodemy of Orthopaedic Surgeons.

JOHN RANKIN, M.D.
Madison, Wisc.



Faculty, University of Wisconsin School of Medicine. M.D., 1945, University of Wisconsin Medicol School. M.B. ond Ch. B., 1946, University of Glasgow, Scotland. Choirmon, executive committee, foculty division of biological sciences, University of Wisconsin, 1966. Member, Council on Pulmonory Research, Americon College of Chest Physicions. Member, executive committee, Wisconsin Chopter, Americon College of Chest Physicions. Member, Royol College of Physicions (Londonl, Royol Co!lege of Physicions ond Surgeons (Glasgow), Americon Thorocic Society, Americon Physiologicol Society.

JAMES F. GLENN, M.D.
Durham, N.C.



Professor of urology, Duke University School of Medicine. Chief, division of urologic surgery, Duke University Medicol Center ond offilioted hospitols. M.D., 1952, Duke University School of Medicine. Member, editoriol boords of Monogrophs in the Surgicol Sciences, Urology Digest ond Urologicol Survey. Member, American Associotion of Genitourinory Surgeons; Americon College of Surgeons; Americon Urologicol Associotion; Pan Americon Medicol Associotion; the Soc'ety for Pediatric Urology ond mony others.

Kentucky Chapter, American College of Chest Physicians

Room 104—Convention Center

Fireside Conferences

2:00 **"The Family Physician in Treatment of TB and Fungi"**
Michael L. Furcolow, M.D., Lexington, and Grover B. Sanders, M.D., Louisville, Moderators

"Treatment of Emphysema"
William H. Anderson, M.D., Louisville, Gilbert L. Hamilton, M.D., Harlan, and John Rankin, M.D., Madison, Wisc., Moderators

"The Diagnosis and Treatment of Pulmonary Embolism"
Gordon K. Danielson, M.D., Lexington, and John L. Wolford, M.D., Louisville, Moderators

"Clinical Cardiology"
Leonard S. Gettes, M.D., Lexington, and Walter S. Coe, M.D., Louisville, Moderators

"Problems in X-Ray Diagnosis"
David Shapiro, M.D., Louisville, and Harold Q. Davis, M.D., Louisville, Moderators

"Clinical Electrocardiography"
Morris M. Weiss, Jr., M.D., Louisville, and Ralph Shabetai, M.D., Lexington

3:00 **Intermission—Visit Exhibits**

3:30 **Resume Fireside Conferences**

Kentucky Dermatological Society

General Hospital

2:00 **Dermatology Clinic at General Hospital**

3:00 **Intermission—Visit Exhibits**

3:30 **"Discussion of Clinic Cases"**
Adolph Rostenberg, Jr., M.D., Chicago, Ill.

Kentucky Industrial Medicine Association

Room 205 — Convention Center

2:00 **"Aerospace Medicine: A New Working Environment for Man" (A continuation of the General Session Presentation)**
Walter W. Kemmerer, M.D., Houston, Texas

3:00 **Visit Exhibits**

Kentucky Orthopaedic Society

Assembly Hall—Convention Center

2:00 **"Arthrodesis of the Hip—A New Technique"**
Theodore A. Fox, M.D., Chicago, Ill.

2:30 **"Treatment of Hip and Pelvic Fracture-Dislocations"**
Harold M. Childress, M.D., Jamestown, N. Y.

3:00 **Visit Exhibits**

3:30 **"Complications of Innominate (Salter) Osteotomy"**
William G. Wheeler, M.D., Nashville, Tenn.

4:00 **"An Improved Ischial Weight Bearing Brace for the Treatment of Legg-Perthes' Disease"**
Frank E. Pollock, M.D., Winston-Salem, N. C.

PETER SAFAR, M.D.
Pittsburgh, Pa.



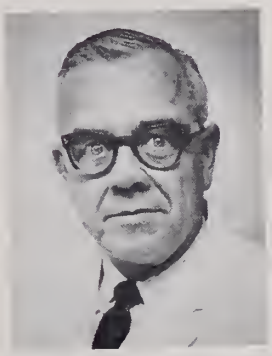
Professor and chairman, department of anesthesiology, University of Pittsburgh School of Medicine. Chief anesthesialogist, Presbyterian - University Hospital. Surgeon General, U.S. Army. M.D., 1948, University of Vienna. Chief, department of anesthesiology, National Cancer Institute, Lima, Peru, 1952-1953. Founder of first residency of anesthesiology in Peru. Member, American Society of Anesthesialogists; Pennsylvania Society of Anesthesialogists; Pan American Medical Association; Association of University Anesthetists; American Physialogicol Society and many others. Past president of the Maryland State Society of Anesthesialogists.

ADOLPH ROSTENBERG, JR., M.D.
Chicago, Ill.

Professor and head of department of dermatology, University of Illinois. M.D., C.M., 1931, McGill University School of Medicine. Consultant for Food and Drug Administration, 1945-1961; Hines Veterans Administration Hospital, 1950 to date; and National Better Business Bureau, 1958 to date. Member, American Academy and Board of Dermatology and Syphilology, American and Chicago Dermatological Societies, Institute of Medicine of Chicago, and National Research Council of the National Academy of Sciences.



WILLIAM A. HOWARD, M.D.
Washington, D.C.



Clinical professor and chairman, department of pediatrics, George Washington University School of Medicine. Chief of pediatrics, George Washington University Hospital. Chief, allergy division, Children's Hospital, D.C. M.D., 1934, Tulane University School of Medicine. Post president, Society of Medical Consultants to the Armed Forces. State chairman for D.C., American Academy of Pediatrics. Member, Sub-board of Pediatric Allergy, American Board of Pediatrics; American Association for the Advancement of Science, and Southern Society for Pediatric Research. Fellow, American Academy of Allergy.

NOTE

The Journal did not receive the photograph and biographical information on Walter W. Kemmerer, M.D., guest of the Kentucky Industrial Medicine Association, in time for publication in this issue. Details will appear in the September issue.

Kentucky Chapter, American Academy of Pediatrics

Room 101—Convention Center

2:00 "Allergy"
William A. Howard, M.D., Washington, D.C.
3:00 Intermission-Visit Exhibits
3:00 "Allergy"
William A. Howard, M.D., Washington, D.C.
4:00 Discussion of new government programs relating to children

Kentucky Urological Society

Room 208—Convention Center

2:00 "Surgery of Adrenal Diseases"
James F. Glenn, M.D., Durham, N.C.
3:00 Intermission—Visit Exhibits
3:30 "Present Status of Renal Transplantation at Their Respective Institutions"
Kenneth Walton, M.D., Lexington, and James F. Glenn, M.D., Durham, N.C.
4:00 Pyelogram Clinic
4:45 Business Meeting

WEDNESDAY, SEPTEMBER 27

MORNING SESSION

General Session

Theme—"Allergy"

9:00 "The Allergic Child: A Profile"
William A. Howard, M.D,. Washington, D.C.
9:20 "Drug Reactions"
Adolph Rostenberg, Jr., M.D., Chicago, Ill.
9:40 "Asthma"
Norman K. Cohen, M.D., Louisville
10:00 Intermission—Visit Exhibits
10:30 "What's New" Symposium
Internal Medicine—Beverly T. Towery, M.D., Louisville
Obstetrics and Gynecology—John W. Greene, M.D., Lexington
Pediatrics—Vernon L. James, Jr., M.D., Lexington
Pathology—Donald R. Kmetz, M.D., Louisville
Psychiatry—Warren M. Cox, M.D., Louisville
11:30 Presentation of Scientific Exhibit Award

PRESIDENT'S LUNCHEON
Flag Room, Kentucky Hotel

11:50

Robert E. Pennington, M.D., London, KMA President, presiding

Invocation
The Rev. Dr. Henry Pope Mobley, Highland Presbyterian Church, Louisville
Recognition
Robert E. Pennington, M.D.
Awards Presentation
Richard F. Grise, M.D., Bowling Green, Chairman, KMA Awards Committee
"Life Among the Comic Strip Heroes and Heroines"
Nicholas P. Dallis, M.D., Scottsdale, Arizona, author of "Rex Morgan, M.D."

SATORU NAKAMOTO, M.D.
Cleveland, Ohio



Head of Dialysis Unit, Cleveland Clinic Foundation. M.D., 1951, The Yomoguchi Medical School, Japan. M.S., 1959, University of Colorado. Recipient of Science Research Award-Kidney Transplant of the Interstate Postgraduate Medical Association of North America in 1965. Member, American Society for Artificial Internal Organs, American Heart Association and New York Academy of Science.

WINDSOR S. DAVIES, M.D.
Detroit, Mich.



Clinical professor of ophthalmology, Wayne State University School of Medicine. Chief, pathology department, Kresge Eye Institute. Chief, department of ophthalmology, Harper Hospital; associated with six other Detroit hospitals. M.D., 1932, M.S., 1936, University of Michigan Medical School. Member, American Academy of Ophthalmology and Otolaryngology; American Ophthalmological Society; Association for Research in Ophthalmology and Pan American Ophthalmological Society. Past president of the Detroit Ophthalmological Society.

LOREN J. HUMPHREY, M.D. Ph.D.
Lexington, Ky.



Associate professor of surgery and cell biology, University of Kentucky Medical Center. Former assistant professor of surgery, State University of New York at Buffalo. M.D., 1956, M.S., 1960, University of Illinois. Ph.D., 1967, State University of New York at Buffalo. Fellow, American College of Surgeons. Member, New York Academy of Sciences, Christian Medical Society, American Association for the Advancement of Science, Society of University Surgeons, Central Surgical Society.

WEDNESDAY, SEPTEMBER 27
AFTERNOON SESSION

General Session

2:00 "Gastrointestinal Hemorrhage" Transatlantic CPC

KMA Panel Members

Samuel H. Cheng, M.D., Louisville, Moderator
James C. Drye, M.D., Louisville
Ji-Toong Ling, M.D., Louisville
Arthur M. Schoen, M.D., Louisville

Panel Members in England

Professor Richard Welbourn, London, Moderator
Professor Robert Steiner, London
Doctor F. Avery Jones, London

3:00 Intermission—Visit Exhibits

Theme—"Organ Transplants—Present and Future"

3:30 "Make Your Choice Between A Kidney Transplant and Chronic Dialysis"
Satoru Nakamoto, M.D., Cleveland, Ohio

3:50 "Corneal Transplantation"
Windsor S. Davies, M.D., Detroit, Mich.

4:10 "Clinical Transplantation: Patient Selection and Long-Term Care"
Loren Humphrey, M.D., Lexington

4:30 "Radiographic Contributions to Organ Transplantation"
Frederic N. Silverman, M.D., Cincinnati, Ohio

THURSDAY, SEPTEMBER 28
MORNING SESSION

General Session

Theme—"Therapeutic Abortions"

9:00 "Pro-Aspects of Therapeutic Abortions"
Philip S. Crossen, M.D., Lexington

9:20 "Con-Aspects of Therapeutic Abortions"
Humbert Riva, M.D., East Orange, N.J.

9:40 "The Forensic Pathologist Looks at Fatal Criminal Abortion"
Lester Adelson, M.D., Cleveland, Ohio

10:00 Intermission—Visit Exhibits

10:30 "Psychiatric Implications in Therapeutic Abortions"
Nat T. Winston, Jr., M.D,. Nashville, Tenn.

10:50 "A History of Therapeutic Abortions and Their Legal Implications"
Franklin J. Evans, M.D., LL.B. Coral Gables, Florida

Theme—"Birth Control"

11:10 "Recent Trends in Family Planning"
Louise Hutchins, M.D., Berea

11:30 Question-and-Answer Session

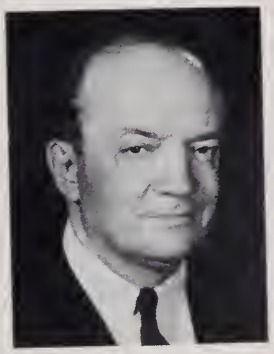
FREDERIC N. SILVERMAN, M.D.
Cincinnati, Ohio



Professor of pediatrics and of radiology, University of Cincinnati College of Medicine. Attending physician, The Children's Hospital and Cincinnati General Hospital. Associate, Children's Hospital Research Foundation. M.D., 1939, Syracuse University College of Medicine. Member, editorial boards of Pediatrics and Progress in Pediatric Radiology. Past president, Society for Pediatric Radiology. Member, American Academy of Pediatrics; American Association for the Advancement of Science; Cincinnati Pediatric Society and the American Pediatric Society.

HUMBERT L. RIVA, M.D.
East Orange, N.J.

Professor and chairman, department of gynecology and obstetrics, New Jersey College of Medicine. Military consultant in obstetrics and gynecology at Walter Reed-Army Institute of Research and the Armed Forces Institute of Pathology for Medical Illustration, Motion Pictures and Television Programming. Former director, department of gynecology, Jersey City Medical Center. M.D., 1939, University of Pittsburgh Medical School. Consultant in obstetrics and gynecology to the Surgean General United States Army, 1952-1961. Member, American College of Surgeons, American College of Obstetricians and Gynecologists, Continental Gynecologic Society, Military Surgeons, and American Association of Obstetricians and Gynecologists.



LESTER ADELSON, M.D.
Cleveland, Ohio



Chief pathologist and chief deputy coroner, Cuyahoga County, Ohio. Associate professor of forensic pathology, Western Reserve University School of Medicine. Assistant professor of legal medicine, WRU Law-Medicine Center. M.D., 1939, Tufts College Medical School. Member, Board of Editors, American Journal of Clinical Pathology; American Society of Clinical Pathologists; American Academy of Forensic Sciences; American Association of Pathologists and Bacteriologists; Cleveland Police and Fire Department Medical Boards of Consultants. Past president of the Cleveland Society of Pathologists.

Specialty Group Meeting

Kentucky Eye, Ear, Nose and Throat Society

Room 205—Convention Center

9:00 "Iris Melanomas"
Windsor S. Davies, M.D., Detroit, Mich.

9:30 "Swellings of the Neck"
Emanul M. Skolnik, M.D., Chicago, Ill.

10:00 "Template Technique in Cleft Lip Surgery"
(Motion picture included)
R. C. Kratz, M.D., Newport

10:30 "Complications of Retinal Detachment Surgery"
Walter R. Morris, M.D., Louisville

11:00 Business Meeting—Election of Officers

12:00 President's Luncheon, Shipp Room, Kentucky Hotel

THURSDAY, SEPTEMBER 28

AFTERNOON SESSION

Specialty Group Sessions

(Nine Specialty Groups will meet on Thursday afternoon. There will be no General Scientific Session at that time. All KMA members are cordially invited to attend these meetings.)

Kentucky Eye, Ear, Nose and Throat Society

Room 205—Convention Center

1:30 "Conservation Surgery of the Larynx"
Emanuel M. Skolnik, M.D., Chicago, Ill.

2:00 "Complications of Cataract Extraction from a Clinical-Pathological Standpoint"
Windsor S. Davis, M.D., Detroit, Mich.

2:30 "Fluorescein Fundus Photography"
William C. Edwards, M.D., Louisville

3:00 Intermission

3:15 "Carotid Arteritis"
Francis J. Piesel, M.D., Louisville

3:45 *(Motion Pictures)*
"Subarachnoid Endolymphatic Shunt for Meniere's Disease"
William F. House, M.D.
Ted N. Steffen, M.D.
"Keratomileusis"
Jose Barraquer, M.D.

Kentucky Chapter, American Academy of General Practice

Second Floor Auditorium—Convention Center

2:00 "A Physician's Dilemma Regarding Resuscitation in Cardiac Arrest"
Franklin J. Evans, M.D., LL.B. Coral Gables, Fla.

2:30 "Management of Common E.N.T. Problems: i.e., Vertigo, Sinusitis, Chronic Otitis Media, Serous Otitis, etc."
Robert C Kratz, M.D., Newport

3:00 Intermission—Visit Exhibts

3:30 "Common Foot Problems in Infants and Children"
William C. Mitchell, M.D., Louisville

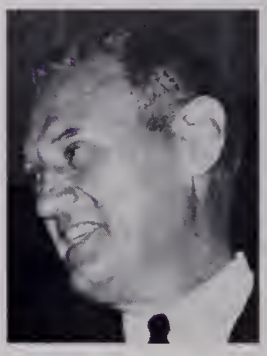
4:00 "Local and Regional Anesthesia for the Family Doctor"
Eugene H. Conner, M.D.,Louisville

NAT T. WINSTON, JR., M.D.
Nashville, Tenn.



Commissioner of Mentol Heolth af Tennessee. M.D., 1953, Vanderbilt University Schaal af Medicine. Surgical residency, University af Virginia Haspital. Psychiatric residency, Vanderbilt University Schaal of Medicine. First superintendent, Maccosin Bend Psychiotric Haspital, Chattanaaga, where he instituted the new milieu pragram far treatment af the mentally ill. Member, American Psychiatric Assaciation.

FRANKLIN J. EVANS, M.D., LL.B.
Coral Gables, Fla.



Clinical assistant prafessar af legal medicine, University af Miami Schaal of Medicine. Farmer instructar in medical jurisprudence, University af Miami Schaal af Law. M.D., 1941, New Yark University Callege af Medicine. LL.B., New Yark University Schaal af Law. Past president, Dade Caunty Medical Assaciatian and Flarida Academy af General Practice. Fellaw, American Academy af Farensic Sciences. Member, Sauthern Medical Assaciatian, American Acodemy af General Practice, Dade Caunty Bar Assaciatian. Baard af Advisars, Dactars far American Yauth.

LOUISE G. HUTCHINS, M.D.
Berea, Ky.



Valunteer in pediatric service, Berea College Haspital. Chairman, Madisan Caunty Baard af Health. President, Mauntain Maternal Health League. M.D., 1936, Yale. D.Sc., 1967, Berea College. Charter member, American Assaciatian af Planned Parenthaad Physicians. Past president, Berea Waman's Club. Semifinalist, Lane Bryant Annual Award far Distinguished Valunteer Service, 1964; ane af six finalists, 1966

HARWELL WILSON, M.D.
Memphis, Tenn.



Prafessar and chairman, department af surgery, Universi y af Tennessee. Surgean-in-chief, City af Memphis Haspita's since 1948. M.D., 1932, Vanderbilt University Schaal af Medicine. Praducer af teaching matian pictures and authar af numerous surgical articles. Natianal treasurer, American College af Surgeans. Member, American Surgical Assaciatian, Saciety af University Surgeans, Saciety of Vascular Surgery Sauthern Surgical Assaciotion.

Kentucky Obstetrical and Gynecological Society

Room 101—Convention Center

2:00 "Occurrence of Endometrial Malignancy Following Previous Treatment with Radium for Benign and Malignant Conditions"
Humbert Riva, M.D., East Orange, N.J.
2:30 "Review of State Health Department Program of Cervical Cytology Screening"
C. Hernandez, M.D., Frankfort
3:00 Intermission—Visit Exhibits
3:30 "Maternity and Infant Program in Rural Appalachia"
Margaret Livengood, M.D., Berea

Kentucky Chapter, American College of Physicians

Room 203—Convention Center

2:00 "Results of Intensive Health Survey in Apparently Healthy Executives"
Allen L. Cornish, M.D., Lexington
2:30 "The Practicality of Home Dialysis and Dialysis in Small Hospitals"
Saturo Nakamoto, M.D., Cleveland, Ohio
3:00 Intermission—Visit Exhibits
3:30 "The Intensive Cardiac Care Unit in a Community Hospital"
W. A. Litzenberger, M.D., Elizabethtown
4:00 "Myocardial Rupture as a Complication of Myo-Cardial Infarction"
F. Albert Olash, M.D., Louisville

Kentucky Society of Pathologists

Room 208—Convention Center

2:00 "SNOP"
M. David Orrahood, M.D., Owensboro
2:20 "Focal Oxyphilic Change of Connective Tissue"
Yung Kook Im, M.D., Covington
2:40 "Some Diagnostic Applications of Enzyme Histochemistry"
Herbert Braunstein, M.D., Lexington
3:00 Intermission—Visit Exhibits
3:30 "The Pathologist Looks at Homicide"
Lester Adelson, M.D., Cleveland, Ohio

Kentucky Psychiatric Association

Room 204—Convention Center

2:00 "Community Mental Health and Private Psychiatrists"
Nat T. Winston, Jr., M.D., Nashville, Tenn.
3:00 Intermission—Visit Exhibits
3:30 Business Meeting

Kentucky Chapter, American College of Radiology

Room 306—Convention Center

2:00 "Errors in the Diagosis of Achrondroplasia"
Frederic Silverman, M.D., Cincinnati, Ohio
3:00 Intermission—Visit Exhibits
3:30 "Cancer in the Head and Neck Region Treated by Integration of Radiation and Operation"
Robert Greenlaw, M.D., Lexington
4:00 "Contrast Laryngography"
Edward N. Maxwell, M.D., Louisville

Kentucky Chapter, American College of Surgeons

Room 104 — Convention Center

2:00 "The Good and Bad of Open Heart Surgery"
W. Fielding Rubel, M.D., Louisville
2:30 "Cartoid Body Tumor, Recent Advances and Diagnosis and Surgical Treatment"
Harwell Wilson, M.D., Knoxville, Tenn.
3:00 Intermission—Visit Exhibits
3:30 "The Present Status of Cancer Chemotherapy Drugs"
Condict Moore, M.D., Louisville, and
Fitzbaugh Mullins, M.D., Louisville
4:00 "Survey of Inguinal Hernioplasty in Lexington, Kentucky, Preliminary Report"
Herman Playforth, M.D., Lexington, and
Ben Eiseman, M.D., Denver, Colo.

Kentucky Association of Public Health Physicians

Room 207—Convention Center

To be announced

Dr. Hutchins, Program Speaker Honored By Berea College

Berea College conferred an honorary Doctor of Science degree upon Louise G. Hutchins, M.D., Berea, on June 5. Doctor Hutchins, guest of the Kentucky Association of Public Health Physicians, will appear on the scientific program September 28 during the KMA Annual Meeting to discuss "Recent Trends in Family Planning."

Doctor Hutchins, president of the Mountain Maternal Health League, is a charter member of the American Association of Planned Parenthood Physicians. She is active in volunteer service at the Berea College Hospital and chairman of the Madison County Board of Health.

The Citation read at the time of the presentation of the degree to Doctor Hutchins praised her "for her outstanding volunteer service to her community, for her distinguished skill, intelligence and compassion."

Auxiliary Meeting Plans Include Fashion Show Luncheon

A fashion show will be the special feature of a luncheon honoring Mrs. C. C. Long, president-elect of the Woman's Auxiliary to the AMA, during the KMA Woman's Auxiliary Annual Meeting. The luncheon will be held at 12:30 p.m., Wednesday, September 27, in the Crystal Ballroom of the Brown Hotel.

Another highlight of the Auxiliary meeting will be a Hobby Show, featuring materials made by the children of members, which will be on display during the meeting in Room 312 of the Kentucky Hotel.

A Continental Breakfast Buffet will be available to members of the Auxiliary at 8 a.m. Tuesday, September 26, and Wednesday, September 27, in Room 310 of the Kentucky Hotel, according to Mrs. Bernard Schoo, convention chairman.

W. H. Wathen, 1887 President To Be Honored At Meeting

The official title of the 1967 Annual Meeting of the Kentucky Medical Association will be the William Hudson Wathen Memorial Meeting, honoring the memory of the Association's 1887 President.



The Association established the tradition of honoring a past president of KMA or some other outstanding physician at the Annual Meeting in 1935.

A comprehensive biography of Doctor Wathen, a Louisville surgeon, has been written by Eugene H. Conner, M.D., Louisville, KMA historian, for the program booklet which will be available at the Annual Meeting in Louisville, September 26, 27 and 28.

WOMAN'S AUXILIARY to the Kentucky Medical Association

General Information

REGISTRATION

Lobby, Kentucky Hotel

Monday	12 Noon - 5:00 PM
Tuesday	7:30 AM - 5:00 PM
Wednesday	9:00 AM - 11:00 AM

(All times are Eastern Standard)

PRE-CONVENTION HEALTH CAREERS WORKSHOP

ROOM 1510, MONDAY, SEPTEMBER 25, 2-4 PM

Mrs. Herbert J. Ulrich, Buffalo, N.Y., conductor, assisted by Mrs. Harold Barton, Health Careers Chariman, and Mrs. Hoyt Gardner, Co-chairman.

Tuesday, September 26

Continental Breakfast, Room 310, 8-10 AM.

Pre-convention Board Breakfast (subscription): 8 AM Parlor B, Kentucky Hotel. All general officers, chairmen of standing and special committees, three immediate past presidents, councilors, co-ordinator for members-at-large and county auxiliary presidents are urged to attend.

Formal Opening of Convention: 10 AM, Mirror Room, Kentucky Hotel

Luncheon (subscription) honoring past presidents, members-at-large and distinguished guests: 12:30 PM, Terrace Room

Formal Convention Session: 2 PM

Wednesday, September 27

Continental Breakfast, Hospitality Room, 310, 8-9:15 AM

Business Meeting: 9:15 AM, Mirror Room, Kentucky Hotel

Luncheon—Fashion Show (subscription) honoring Mrs. C. C. Long, President-elect, Woman's Auxiliary to the AMA: 12:30 PM, Crystal Ballroom, Brown Hotel

Gavel Club Dinner for Past State Presidents: 7 PM

Thursday, September 28

Post-convention Board Breakfast (subscription): 8:45 AM, Parlor A

VISIT THE HOSPITALITY ROOM, ROOM 310, AND THE HOBBY SHOW, ROOM 312, KENTUCKY HOTEL

1967 State Convention Committees

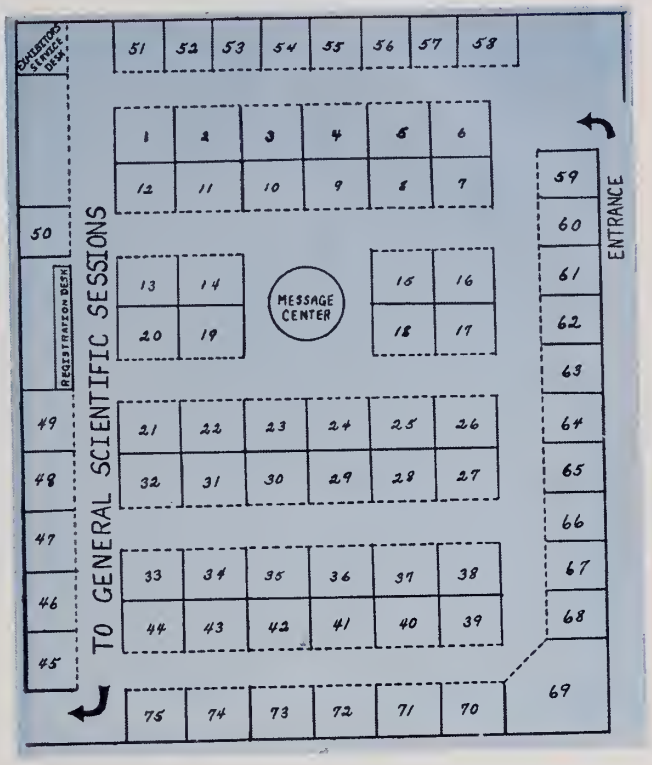
General Chairman	Mrs. Bernard J. Schoo, Louisville
Co-Chairman	Mrs. James E. Ryan, Louisville
Registration	Mrs. Roger L. Queen, Louisville
Decorations	Mrs. Parnell Rollings, Louisville
Finance	Mrs. William C. Durham, Louisville
Tuesday Luncheon	Mrs. Daniel W. Burke,
Co-Chairman	Mrs. Norman H. Liebschutz,
Pre-convention and Post-convention Breakfast and Tuesday Luncheon tickets	Mrs. Lloyd G. Yopp, Louisville
Wednesday Luncheon	Mrs. Daniel W. Burke,
Co-Chairman	Mrs. Norman H. Liebschutz,
Fashion Show	Mrs. S. Randolph Scheen, Louisville
Fashion Show Tickets	Mrs. William F. Hawn, Louisville
Publicity	Mrs. Daniel W. Burke, Louisville
Hobby Show	Mrs. Robert B. Nolan, Louisville
Gift Drawing	Mrs. Edwin T. Davis, Paducah
Hospitality Room	Mrs. George W. Schafer, Louisville
Exhibits	Mrs. W. Proctor Eubank, Louisville
Official Hostesses	Mrs. Kenneth W. Hodge, Louisville
	Mrs. Norvin L. Casper, Louisville
	Mrs. Irwin H. Cutler, Louisville
	Mrs. Harold Q. Davis, Louisville
	Mrs. John W. Miller, Louisville
	Mrs. Edward P. Solomon, Jr., Louisville
	Mrs. Michael Zeman, Louisville
Tellers	Mrs. Kenneth DeSimone, Greensburg
	Mrs. Barton L. Ramsey, Jr., Somerset
	Mrs. Keith Coverdale, Bowling Green
Pages	Mrs. E. Calven Pifer, Morehead
	Mrs. Harold Priddle, Paducah
	Mrs. J. C. Quertermous, Murray
Timekeepers	Mrs. Loman O. Trover, Earlington
	Mrs. Mark A. Judge, Central City
	Mrs. Richard E. Davis, South Carrollton

Latest Research Developments in Related Fields On Display in Technical Exhibit Area

What are the most recent developments in medical techniques, pharmaceutical products, instruments, and equipment? Your 75 technical exhibitors offer you an unparalleled opportunity to see and hear about the latest research developments in related fields.

The presentations of the carefully selected exhibitors are calculated to provide a rewarding and stimulating exchange of ideas. A visit to the technical exhibits gives you a chance to weigh the merits of services and products bearing a close relationship to your practice.

So that you and every KMA member will have an opportunity to visit the exhibits, 30-minute intermissions have been planned for each general session and specialty group meeting. See you in the exhibit hall!



TECHNICAL EXHIBITORS

Abbott Laboratories (18)
Ames Company (51)
Arm Medical Consultants (73)
Arnar-Stone Laboratories (2)
Audio Digest (27)
Ayerst Laboratories (47)

Beechman Research Laboratories (42)
Blue Cross-Blue Shield (40)
Borden Company, Pharmaceutical Division (64)
Bristol Laboratories (50)
Burroughs Wellcome & Co. (U.S.A.), Inc. (39)
Burton, Parsons & Company (75)

Carnation Company (56)
Central Dairy Council (62)
Ciba Pharmaceutical Company (12)
Coca-Cola Company (69)
Crocker-Fels Company (46)

Dictaphone Corporation (1)

Eaton Laboratories (7)

Field Enterprises Educational Corporation (57)
Flint Laboratories (45)

Geigy Pharmaceuticals (49)
Gerber Products Company (59)
Guild of Prescription Opticians of Kentucky (9)

Hancock, John Life Insurance (68)
Hewlett-Packard Company (30)
Hoechst Pharmaceutical Company (67)

Kay Surgical, Inc. (31)

Lederle Laboratories (14)
Lee Agency, A.P. (66)
Lilly, Eli and Company (44)
Lippincott, J.B. Company (5)
Logan Company, Sealy Mattress Co. (41)

Malkin Instrument Company (72)
McNeil Laboratories, Inc. (10)
Mead Johnson Laboratories (33)
Medco-Siemens (36)
Medical Protective Company (63)
Merck Sharp & Dohme (21)
Merrell, William S. Company (38)
Meyer Laboratories, Inc. (65)
Monarch Auto Co., Inc. (NW Foyer (Corner)
Mutual Benefit (48)

North American Pharmacal (37)

Ortho Pharmaceutical Corporation (11 & 25)
OTC Professional Appliances (28)

Parke, Davis & Company (15)
Pepsi-Cola (Louisville Bottlers) (53)
Pfizer Laboratories (22)
Poythress, William P. & Company (55)

Ransdell Surgical, Inc. (54)
Reynolds, R.J. Tobacco Company (29)
Richards Manufacturing Company (52)
Robins, A. H. Company (58)
Roerig, J. B. & Company (32)
Ross Laboratories (20)

Sandoz Pharmaceuticals (60)
Saunders, W. B. Company (8)
Schering Corporation (23)
Searle, G. D. & Company (19)
Siemens Medical of America, Inc. (35)
Smith Kline & French Laboratories (13)
Smith, Miller & Patch, Inc. (16)
Squibb, Inc. (6)
Stein Bros. & Boyce, Inc. (71)
Stuart Company, The (Atlas Chemical Industry, Inc.) (74)
Syntex Laboratories, Inc. (70)

Tele-Business Products Company (43)
3M Business Products Sales, Inc. (34)

United States Tobacco Company (3)
U.S. Vitamin & Pharmaceutical Corp. (17)

Westwood Pharmaceuticals (4)
Winthrop Laboratories (26)
Wocher, Max & Son Company (24)

Zimmer Manufacturing Company (61)



THE KMGA GOLF TOURNAMENT will be held at the beautiful, new Hurstbourne Country Club off Shelbyville Road in Louisville Monday, September 25. This annual event is held in conjunction with the KMA Annual Meeting.

Annual KMA Golf Tournament to be at Hurstbourne Country Club Sept. 25

Arrangements have been made to hold the 1967 Kentucky Medical Association Golf Tournament at the Hurstbourne Country Club, 8222 Shelbyville Road, on Monday, September 25. This relatively new and distinctive country club is located in Louisville just east of the interchange of the Watterson Expressway and Shelbyville Road.

The tournament, an annual event, is being held again this year in conjunction with the KMA Annual Meeting in Louisville. The country club will be open that day only to KMA members entering the tournament, according to Donald L. Ware, M.D., Louisville, chairman of the KMA Golf Committee.

All participants will tee off between 10:00 a.m. and 2:00 p.m. KMA members desiring to play in this year's tournament are to submit their dues and application forms prior to the registration deadline of Friday, September 1, (see application form below). Food and refreshments will be available for the golfers at the country club. Caddies and golf carts will also be available.

Permament trophies will be given to low net and low gross winners in the championship and senior division. Other prizes will be presented. The Calloway handicap scoring system will be used, so participants need not submit handicaps.

APPLICATION FOR MEMBERSHIP

KMA Golf Association

Please complete and return immediately to: KMA Golf Committee
Kentucky Medical Association
3532 Janet Avenue, Louisville, Kentucky 40205

Name .....

Address ..... (Town) .....

Amount enclosed: .....$7 (Regular playing member) .....$3 (non-playing member)

....$3 (I am a member of Hurstbourne Country Club) Others I would like to play with are: .....

.....I would like to tee off at the following time .....

TOURNAMENT WILL BE HELD MONDAY, SEPTEMBER 25.

Gubernatorial Candidates To Speak At Annual KEMPAC Seminar

Kentucky's two gubernatorial candidates, Democratic nominee Henry Ward and Republican nominee Louie B. Nunn, will be among the featured speakers at the annual KEMPAC Seminar Monday evening, September 25, in the Flag Room of the Kentucky Hotel. A reception at 6 p.m. will be followed by a dinner at 7 p.m. and the seminar, according to John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board.



Mr. Nunn



Mr. Ward

Another participant who will speak briefly at the seminar is Malcolm C. Todd, M.D., Long Beach, Calif., president-elect of the California Medical Association and an AMPAC Board member.

Mr. Nunn and Mr. Ward have been asked to speak primarily on what the profession can do to make itself a greater force for good in the area of political action, according to C. Kenneth Peters, M.D., Jeffersontown, KEMPAC secretary.

Henry Ward, Louisville, Commissioner of Highways from 1960 to 1966, has also served Kentucky as a five-term member of the House of Representatives, state senator (1946-1948) and Commissioner of Conservation (1948-1955). He became assistant to Senator Clements in 1955 and a year later joined the public relations staff of the National Association of Real Estate Boards in Washington, D.C. He returned to Kentucky in 1957 as an executive of the Louisville Chamber of Commerce.

After graduation from Paducah Tilghman High School in 1928, Mr. Ward began a 20-year newspaper career as a reporter, columnist and then associate editor of the Paducah Sun-Democrat. He was honored by the Junior Chamber of Commerce in 1942 as Outstanding Young Man of Kentucky, by the Kentucky Press Association in 1954 as Kentuckian of the Year, and by WHAS Radio & TV in 1963 as Kentucky Man of the Year.

Mr. Nunn, Glasgow, was elected judge of Barren County in 1953 and for his accomplishments in that office was elected one of "Three Outstanding Young Men of Kentucky" in 1956 by the State Junior Chamber of Commerce. Following his term as a judge, Mr. Nunn was appointed City Attorney by the Glasgow City Council, a position he held until 1958 when he resigned to resume his law practice and take a more active part in Kentucky's growth.

Mr. Nunn became active in state politics in 1956 when he successfully managed the Eisenhower-Cooper-Morton campaign. He also managed the Cooper and Morton campaigns in 1960 and 1962. Mr. Nunn attended Bowling Green Business University and the University of Cincinnati and graduated from the University of Louisville School of Law in 1960.

U of L Alumni To Enjoy Ride On Belle Of Louisville

A special feature of the University of Louisville School of Medicine alumni reunions during the KMA Annual Meeting will be a ride on the Belle of Louisville September 26. Another highlight of the reunions will be a tour of the Medical Center, according to Les Shively, director of U of L alumni relations.

Chairmen of the classes holding reunions this year are listed below. All are in Louisville, with the exception of Charles Rutledge, M.D., Hazard, chairman of the 25-year class.

1922—E. W. Akins, M.D., 896-4393
1927—R. O. Joplin, M.D., 458-3325
1932—C. F. Blankenship, M.D., 454-7289
1937—Charles C. Bryant, M.D., 452-1558
1942—Charles Rutledge, M.D., 436-3121
1947—Ed Warrick, M.D., 895-3126
1952—Burton Heine, M.D., 458-6462
1957—Stanley Collis, M.D., 583-5015
1962—Randall Moore, M.D., 459-1374

The chairman of the 50-year class has not yet been announced. Doctors wishing additional information about the plans for their classes may contact the chairmen at the phone numbers listed above.



BELLE OF LOUISVILLE

REGISTRATION

Please register at the Registration Booth in the north end of the Convention Hall (in the Technical Exhibit Hall) as soon as possible. Hours are from 8:00 a.m. Tuesday, Wednesday and Thursday, September 26, 27 and 28.

You are requested to wear your badges at all times during your attendance at the meeting.

PROGRAM
FORTY-FIFTH ANNUAL CONVENTION
Of The
WOMAN'S AUXILIARY
To The
KENTUCKY MEDICAL ASSOCIATION

SEPTEMBER 26-27-28

1967

KENTUCKY HOTEL **LOUISVILLE, KENTUCKY**

REGISTRATION

Lobby, Kentucky Hotel

Monday	12 Noon - 5:00 PM
Tuesday	7:30 AM - 5:00 PM
Wednesday	9:00 AM - 11:00 AM

(All times are Eastern Standard)

PRE-CONVENTION
HEALTH CAREERS WORKSHOP

ROOM 1510, MONDAY, SEPTEMBER 25, 2-4 PM

Mrs. Herbert J. Ulrich, Buffalo, N.Y., conductor, assisted by Mrs. Harold Barton, Health Careers Chairman, and Mrs. Hoyt Gardner, Co-chairman.

TUESDAY, SEPTEMBER 26

8:00 AM

Pre-convention Board Breakfast (subscription), Parlor B, Kentucky Hotel. All general officers, chairmen of standing and special committees, three immediate past presidents, councilors, co-ordinator for members-at-large and the county presidents are urged to attend.

CONTINENTAL BREAKFAST

Room 310, 8-10 AM

10:00 AM

MIRROR ROOM

Formal opening of the 45th Annual Convention of the Woman's Auxiliary to the Kentucky Medical Association.

Mrs. Raymond E. Jones, President, presiding

Invocation . . . . . Mrs. Morgan Colbert, Louisville, Chaplain

Pledge of Allegiance to the Flag
Mrs. R. Randolph Scheen, Louisville

Pledge of Loyalty . . . . . Mrs. J. Murray Kinsman
Louisville
National Director, Auxiliary to the AMA

Address of Welcome . . . . Mrs. Robert Tate, President
Jefferson County

Presentation of Distinguished Guests
Mrs. Raymond E. Jones, Louisville

Adoption of Convention Rules
Mrs. Earl W. Roles, Louisville
Parliamentarian

Announcements . . . . Mrs. Bernard Schoo, Louisville,
Convention Chairman

Roll Call of Delegates
Mrs. C. E. Hornaday, Owensboro,
Recording Secretary

Minutes of the 44th Annual Meeting
Mrs. C. E. Hornaday

Report of the 1967 National Convention
Mrs. J. Jack Martin, Tompkinsville

Greetings . . . . . Mrs. C. T. Wilkinson, President,
Woman's Auxiliary to the Southern
Medical Association

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. J. Jack Martin

Greetings . . . . . Mrs. Shelley E. Bennett, President,
WA-SAMA, University of Kentucky

Greetings . . . . . Mrs. Richard Sax, President
WA-SAMA, University of Louisville

President's Report . . . . . Mrs. Raymond E. Jones

Report of Officers

President-Elect and Membership Chairman
Mrs. Charles C. Kissinger, Henderson

Vice-Presidents . . . . Mrs. F. H. Hodges, Pikeville
Mrs. James A. Harris, Paducah
Mrs. O. L. May, Danville
Mrs. Joseph B. Parker, Lexington

Treasurer . . . Mrs. William C. Durham, Louisville

Corresponding Secretary . . Mrs. Charles Sergeant,
Louisville

Reports of Councilors

Reports of Chairmen

Unfinished Business

New Business

Amendments . . . . Mrs. Earl W. Roles, Chairman,
By-laws Committee

Resolution about V.D. Control
Mrs. Marvin A. Lucas

Report of the Nominating Committee

Presentation of the 1967-1968 Budget
Mrs. J. Murray Kinsman, Louisville,
Finance Chairman

Election of the 1967-1968 Nominating Committeee

Presentation of "Helping Hands" Award
Mrs. Stewart Hemphill, Danville

Report of Registration . . . . Mrs. Roger L. Queen, Jr.,
Louisville

In Memoriam . . . . Mrs. Morgan Colbert, Chaplain,

Participants . . . . Mrs. Charles B. Stacy, Bell County
Mrs. Robert Tate, Jefferson County
Mrs. Paul Walstad, Harlan County
Mrs. Robert R. Robbins, Muhlenburg
County

LUNCHEON

12:30 PM

TERRACE ROOM

Honoring

Past Presidents, Members-at-large, and Distinguished Guests

Invocation . . . . Mrs. Ballard W. Cassady, Pikeville
Presentation of Membership Awards
Mrs. Charles C. Kissinger
"Vietnam—U.S. Doctors Are There"
George Brockman, M.D., Greenville
Introduction . . . . . Mrs. Harold Graves, Louisville
Chairman, Program Committee

2:00 PM
MIRROR ROOM

Reports of County Auxiliary Presidents
Vice-presidents presiding: Mrs. F. H. Hodges
Mrs. James A. Harris
Mrs. Joseph B. Parker, Jr.
Mrs. O. L. May

Bell, Bourbon, Boyd-Carter-Greenup, Boyle, Calloway, Christian, Daviess, Fayette, Franklin, Fulton, Hardin-Larue, Harlan, Henderson, Hopkins, Jefferson, Johnson-Floyd-Magoffin, Laurel, Madison, Marion-Washington, Mason, McCracken, Muhlenburg, Pike, Pulaski, Rowan, Taylor-Green, Warren, Whitley

WEDNESDAY, SEPTEMBER 27

9:15 AM

MIRROR ROOM

Invocation . . . . . Mrs. Edwin T. Davis, Paducah
Roll Call . . . . . Mrs. C. E. Hornaday
Reading of the Minutes . . . . . Mrs. C. E. Hornaday
Presentation of Distinguished Guests
Announcements . . . . . Mrs. Bernard Schoo
Presentation of Community Service Award
Address . . . . . Mrs. C. C. Long, Ozark, Arkansas,
President-Elect, Woman's Auxiliary to the AMA
Election of Officers
Installation of Officers . . . . . Mrs. C. C. Long
Presentation of Gavel and Pin
Mrs. Raymond E. Jones
Inaugural Address . . . . . Mrs. Charles C. Kissinger
Presentation of Past President's Pin
Mrs. Earl W. Roles
Address . . . . Robert E. Pennington, M.D., London,
President of KMA
Courtesy Resolutions . . . . . Mrs. Bernard Asman

LUNCHEON AND FASHION SHOW

12:30 PM

CRYSTAL BALLROOM

Honoring

Mrs. C. C. Long, President-Elect
Woman's Auxiliary to the American Medical Association

Invocation . . . . . Mrs. Charles B. Stacy, Pineville
Presentation of Distinguished Guests
Presentation of Officers
Fashion Show

THURSDAY, SEPTEMBER 28

8:45 AM

PARLOR A

Post-convention Board Breakfast

Presiding . . . . . Mrs. Charles Kissinger
Invocation . . . . . Mrs. Edwin T. Davis
Meeting of Membership Committee

Oral Cancer Symposium Planned To Follow Annual Meeting

The Second Oral Cancer Symposium, entitled "Special Problems in Oral Cancer", will be held on Friday, September 29, the day following the KMA Annual Meeting, according to Condict Moore, M.D., director of the Oral Cancer Diagnostic Program. The symposium, which is sponsored by the University of Louisville School of Medicine and Dentistry, is scheduled from 9 a.m. to 12:30 p.m. at Rankin Amphitheater of Louisville General Hospital.

The program planned for the symposium follows.

9:00—Introduction—Condict Moore, M.D., associate professor of surgery, University of Louisville School of Medicine

9:20—"Dental Problems in Radiation Therapy"—Harold Boyer, D.M.D., associate dean, University of Louisville School of Dentistry

9:40—"Pre and "Post-Operative Radiation Precautions in Oral Cancer"—Ralph Scott, M.D., professor of radiology, University of Louisville School of Medicine

10:00—Discussion

10:15—Coffee

10:35—Movie—"Early Cancers of the Larynx"—Edwin Cocke, M.D., otolaryngologist, Memphis, Tenn.

11:00—"Adenomatous Tumors of the Mouth"—Sheldon Rovin, D.M.D., associate professor of oral pathology, University of Kentucky School of Dentistry

11:20—"Verrucous Carcinomas of the Mouth"—Benjamin Rush, Jr., M.D., professor of surgery, University of Kentucky School of Medicine

11:45—Discussion

12:30—Adjournment

Please Take This Issue Home

Your wife will be interested in reading about the special features of the meeting of the Woman's Auxiliary to KMA presented in this issue and will enjoy the sections devoted to the activities planned for the regular KMA Annual Meeting. You are urged by KMA President, Robert E. Pennington, M.D., to take this issue home to your wife.

ORGANIZATION SECTION

Dr. Long Re-elected Member Of AMA Board of Trustees

Robert C. Long, M.D., Louisville, was re-elected by acclamation to a second full term as a member of the Board of Trustees of the American Medical Association during the organization's Annual Meeting, June 12-22, in Atlantic City.



Doctor Long

Doctor Long was elected to the Board in 1963 to fill an unexpired one-year term and re-elected in 1964 to his first full term. His election in 1964 was also by acclamation.

During the past year, Doctor Long has served the AMA as a member of the Board's Executive Committee and as a member of the Education and Research Foundation Board.

Dr. Rainey Stresses Need to Know State Candidates, Congressmen

The importance of personally knowing your candidates for state representatives and senators and those who subsequently take office cannot be too strongly emphasized, according to Fred C. Rainey, M.D., Elizabethtown, chairman for State Affairs of the KMA Council on Legislative Activities.

Doctor Rainey has suggested that each physician should have a thorough knowledge of the representative's or senator's philosophy and his background. Every physician, Doctor Rainey said, has an obligation to have the kind of relationship with his senator or representative which will enable him to assist the office holder in better understanding health and medical care problems.

While in some cases winning the primary was tantamount to being elected in November, Doctor Rainey stressed the need for establishing contact with the candidates and giving tangible support to the candidate who would best serve the public interest.

AMA Names Dr. Wilbur Pres.-Elect; Installs President Rouse

Dwight L. Wilbur, M.D., a San Francisco physician, was named president-elect of the American Medical Association by the House of Delegates on June 21 at the Annual Meeting in Atlantic City. Milford O. Rouse, M.D., Dallas, was installed as the Association's 122nd president during the meeting.



Doctor Wilbur



Doctor Rouse

Before his election in 1966, Doctor Rouse had served the AMA as speaker of the House of Delegates since June, 1963, and as vice-speaker during the four preceding years. A 1927 graduate of Baylor University College of Medicine, Doctor Rouse has practiced in Dallas since 1928, specializing in gastroenterology. He has been clinical professor of medicine at the University of Texas Southwestern Medical School since 1943.

Doctor Wilbur has been a member of the AMA's Board of Trustees since 1963 and has served as a delegate for 17 years. He graduated from the University of Pennsylvania in 1926 and has practiced as an internist and gastroenterologist for 36 years. He has been on the clinical faculty at Stanford University School of Medicine for 30 years.

Doctor Wilbur has served for 21 years as editor of California Medicine. He is a past president of the American Gastroenterological Association and of the American College of Physicians. He is a diplomate of the American Board of Internal Medicine. Doctor Wilbur has served as a member of the Board of Trustees of the Mayo Foundation since 1951.

The election of Doctor Wilbur marks the first time in the history of the AMA that the son of a former president has been selected for that office. He is the son of the late Ray Lyman Wilbur, M.D., who served in 1923-24 as the Association's 76th president.

Dr. Harkess Arrives at U of L

James W. Harkess, M.D., Augusta, Georgia, the first occupant of the newly established Kosair chair of orthopedic surgery in the University of Louisville School of Medicine, arrived in Louisville July 17.

The Charities Committee of Kosair Temple and the University of Louisville have provided funds for the support of Doctor Harkess' work of which clinical research will be an important part.

Three Trustee Districts Hold Annual Meetings In July

The Thirteenth, Fourteenth and Fifteenth Trustee Districts of KMA held their annual meetings in July. Robert E. Pennington, M.D., London, KMA president, was the featured speaker at all of the meetings.

The Thirteenth District met July 5 at the Holiday Inn, South Point, Ohio. The Boyd County Medical Society was host for the meeting.

The Fourteenth District held their meeting July 6 at Green Meadows Country Club in Pikeville. A scientific program preceded the dinner meeting. Cecil Grumbles, M.D., Louisville, a member of the KEMPAC Board, spoke at the July 5 and 6 meetings.

The meeting of the Fifteenth District was held July 12 at the Mountainaire Motel in Harlan. A scientific program was given in the afternoon, and David B. Stevens, M.D., Lexington, discussed the activities of KEMPAC at the dinner meeting.

Dr. Quertermous Serves On AMA Reference Committee

John C. Quertermous, M.D., Murray, one of Kentucky's delegates to the 116th AMA Annual Meeting, June 18-22 in Atlantic City, served on Reference Committee D at the meeting. The 11-page report of Reference Committee D dealt with numerous resolutions and reports in the general area of socioeconomic problems as they relate to hospital and prepayment plans.

J. Thomas Giannini, M.D., senior delegate from Louisville, led the Kentucky delegation which also included delegate Charles C. Rutledge, M.D., Hazard. Kentuckys' three alternate delegates were also present for the meeting. They are Charles G. Bryant, M.D., Louisville, William W. Hall, M.D., Owensboro, and David B. Stevens, M.D., Lexington.

Attending their respective meetings at the convention also were Robert E. Pennington, M.D., London, KMA president; George F. Brockman, M.D. Greenville, president-elect; Mrs. Raymond E. Jones, Louisville, president of the Woman's Auxiliary to KMA, and Mrs. Charles C. Kissinger, president-elect.

Barbourville Surgeon Completes Flight Around The World

Francis X. Sommer, M.D., a Barbourville surgeon, completed a five-week flight around the world June 25 to commemorate the journey of Charles Lindberg 40 years ago. Doctor Sommer was accompanied by John Rieger, M.D., a California obstetrician, on the 18,000 mile trip in a small single-engined monoplane.

Several portions of Lindbergh's famous flight were duplicated by the two physicians, including the direct journey from New York to Paris and the Arctic route from Tokyo to Alaska. Other stops included Nice, Rome, Athens, Istanbul, Tehran, Bangkok and Hong Kong.

Doctor Sommer, a native of Boston, graduated from Yale University School of Medicine in 1940 and has practiced in Corbin and Knoxville. He is a part-time instructor at Union College.

AMA Woman's Auxiliary Elects Mrs. Kinsman To Board

Mrs. J. Murray Kinsman, Louisville, was elected to a two-year term on the Board of Directors of the Woman's Auxiliary to the American Medical Association June 21 during the Auxiliary's Annual Convention in Atlantic City.



Mrs. Kinsman

Mrs. Kinsman, who had just completed a one-year term on the Board, served as president of the Woman's Auxiliary of the Kentucky Medical Association in 1963-64. She is also a past president of the Jefferson County Medical Society Woman's Auxiliary.

An active participant in Health and Welfare Council activities in Louisville, Mrs. Kinsman has served as a member of the Executive Committee, chairman of the Health Division Planning Committee and as a member of the Citizen's Committee.

BC-BS Announces Staff Promotions

With the elevation of J. Ed McConnell to the presidency of the Kentucky Blue Cross-Blue Shield Plans, as successor to D. Lane Tynes who retired July 1, several promotions in the executive staff have been announced by the organization.

Avil L. McKinney has now been made director of external operations; John Boyle, assistant to the president; John Watkins, director of internal operations; and Ted Lechner, assistant director of internal operations.

Int. Med. Soc. Elects Officers

The Kentucky Society of Internal Medicine named Lewis Dickenson, M.D., Glasgow, president-elect at its annual meeting May 24 in Louisville. Other officers elected are Karl C. Kelty, M.D., president, and John E. Myers, Jr., M.D., secretary-treasurer. Both doctors are from Lexington.

Robert S. Long, M.D., Omaha, Nebraska, president-elect of the American Society of Internal Medicine, was guest speaker at the meeting. The Society will hold its fall meeting September 28 in Louisville.

AMA Lists Kentucky Registrants at Annual Convention in Atlantic City

A total of 73 Kentucky physicians registered at the Annual Convention of the American Medical Association June 18-22 in Atlantic City. The list of registrants, according to records received from the AMA by the Kentucky Medical Association, follows.

LOUISVILLE

William H. Anderson, M.D.
George F. Archer, M.D.
M. Atik, M.D.
John T. Bate, M.D.
Charles G. Bryant, M.D.
John J. Casey, M.D.
M. R. Cronen, M.D.
Elbert L. Dennis, M.D.
J. Thomas Giannini, M.D.
R. F. Greathouse, M.D.
John S. Harter, M.D.
J. C. Hill, M.D.
Arthur T. Hurst, M.D.
Robert C. Long, M.D.
Robert W. Lykins, M.D.
James F. Molloy, M.D.
Irving B. Perlstein, M.D.
Gradie R. Rowntree, M.D.
Marjorie Rowntree, M.D.
N. A. Saliba, M.D.
Charles B. Severs, M.D.
Stanley E. Smith, M.D.
John D. Winebrenner, M.D.
Carroll L. Witten, M.D.

LEXINGTON

Robert N. Class, M.D.
Stephen J. Goldberg, M.D.
Joseph Hamburg, M.D.
Arthur A. Hellebusch, M.D.
V. A. Jackson, M.D.
H. M. Kauffman, Jr., M.D.
W. G. Malette, M.D.
Walker P. Mayo, M.D.
William H. McBeath, M.D.
Franklin B. Moosnick, M.D.
David O'Brien, M.D.
Nicholas J. Pisacano, M.D.
J. J. Rams, M.D.
Edward H. Ray, Jr., M.D.
Edward H. Ray, Sr., M.D.
David B. Stevens, M.D.
Tom F. Whayne, M.D.
William R. Willard, M.D.
Arnold C. Williams, M.D.

OTHER CITIES

W. E. Becknell, M.D., Manchester
C. M. Blanton, M.D., Paducah
Susan J. Brenner, M.D., McDowell
George F. Brockman, M.D., Greenville
Duvon C. Corbitt, Jr., M.D., Wilmore
L. L. Cull, M.D., Frankfort
Robert H. English, M.D., Henderson
Dorothy G. Gates, M.D., Berea
Michael M. Hall, M.D., Campbellsville
William H. Hall, M.D., Owensboro
A. C. Hohn, M.D., Harlan
A. C. Kennedy, M.D., Henderson
W. Vernon Lee, M.D., Covington
Potenciano R. Malvar, M.D., Harlan
Wyatt Norvell, M.D., New Castle
Walter L. O'Nan, M.D., Henderson
Earl P. Oliver, M.D., Scottsville
Robert E. Pennington, M.D., London
F. M. Picklesimer, M.D., Paintsville
John C. Quertermous, M.D., Murray
E. Riestra, M.D., Ashland
Robert M. Rowden, M.D., Fort Campbell
Charles C. Rutledge, M.D., Hazard
Otto H. Salsbery, M.D., Covington
Joseph Schickel, M.D., Burkesville
Charles E. Shields, M.D., Fort Knox
Fred J. Sigda, M.D., Madisonville
Kenneth W. Smith, M.D., Middlesboro
Ira F. Wheeler, M.D., Oneida
John Willard, M.D., Harlan

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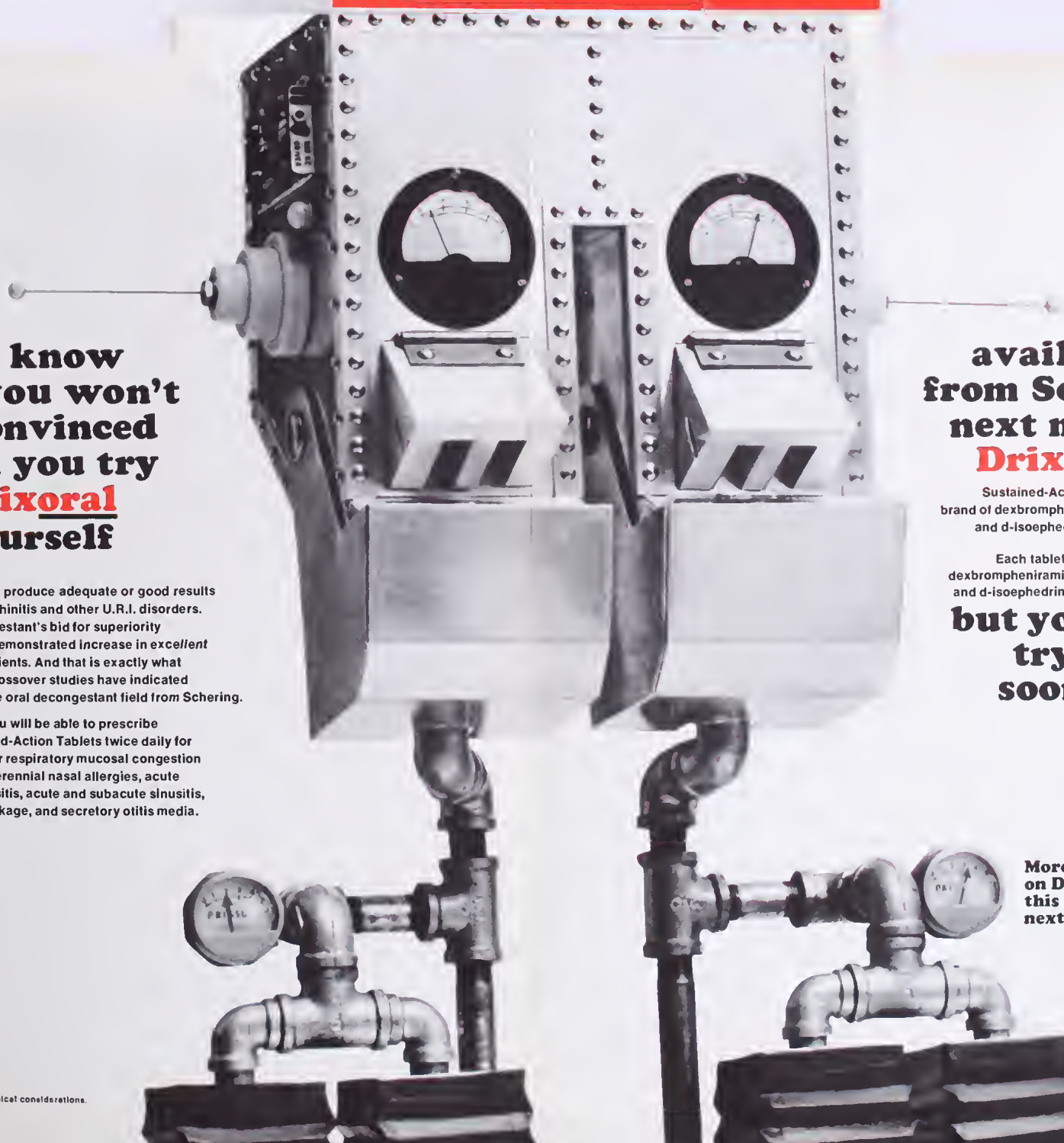
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References:
1. Pullen, F. W. 2nd, and Montgomery, W. W.: Arch. Otolaryng. 77:24, 1963.
2. Frank, D. I.: Curr. Therap. Res. 6:158, 1964.
3. Flarberg, A. A.: Ann. Allergy 22:324, 1964.

5-261

In Memoriam

CLYDE J. NICHOLS, M.D.
Clarkson
1915-1967

Clyde J. Nichols, M.D., the only physician in Clarkson, died July 1 at Norton Memorial Infirmary, Louisville, after an illness of several months. Doctor Nichols graduated from the University of Louisville School of Medicine in 1950. He had practiced in Clarkson since 1951.

Pulmonary Surgery

(Continued from page 764)

any way by the complication of diabetes, nor as the type of surgery performed modified

TABLE VI
DIABETIC COMPLICATIONS

IDOSIS AND KETOSIS	4
POGLYCEMIA	5
)MA	1

/ the presence of diabetes, being determined ily by the tuberculosis status.

No patient had surgery if ketosis was present, ut the severity of the diabetes, as judged by ie amount of insulin or oral anti-diabetic gents required for control, was not considered contraindication for surgery.

This study confirms the fact that diabetic atients tolerate surgery adequately and do not ffer any contraindications to proceeding with ie usual surgical techniques and indications or surgical management when medical therapy ails to inactivate the disease.

References

1. Holden, H. M., and Hiltz, J. E.: The Tuberculous Diabetic, *anad. Med. Assn. J.*, 87:797, 1962.
2. Cheung, O. T.: Treatment of Pulmonary Tuberculosis in iabetic Patients, *Med. Serv. J., Canada*, 18:665, 1962.
3. Chowdhury, A. D., and Mitra, S. K.: Surgical Treatment of ulmonary Tuberculosis Associated with Diabetes Mellitus, *J. ndian Med. Asso.*, 43:260, 1964.
4. Thosteson, G. C., and McKean, R. M.: Thoracoplasty in the uberculous Diabetic Patient, *J. Thoracic Surg.*, 10:682, 1941.
5. El Warraki, S.: The Pattern and Behavior of Pulmonary uberculosis in Diabetic Patients, *Dis. of the Chest*, 43:582, 963.
6. Banyai, A. L.: Diabetes and Tuberculosis, *Dis. of Chest*, 5:238, 1959.

REGISTRATION DEADLINE

September 9 is the deadline to register for the November 7 general election. Your Council on Legislative Activities urges you to ask your family, staff and friends to check their registration to be sure everything is in order.

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ommonly heard complaints from your geriatric pa-nts may indicate an underlying disorder that may quire immediate attention—and definitive therapy. it, with or without an underlying functional illness, e patients' physical and emotional well-being may enhanced by adjunctive steroid-nutritional ther-py. That's why so many patients just like these are itable candidates for MEDIATRIC from their very st visit.

A steroid-nutritional compound (Mediatric) was ed in 100 patients to relieve some of the symptoms used by degenerative changes of aging...." This erapy resulted in improvement of 75 per cent of the tients.

cNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

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KMA Council and Committee Reports

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman of National Affairs and Fred C. Rainey, M.D., Elizabethtown, Chairman of State Affairs, presiding.

KMA Headquarters Office **July 6, 1967**

The Council met for the fourth time during this Associational year to review the activities and reports from the chairmen of National and State Affairs and the Committee on Cults to the House of Delegates.

The Council discussed the results of the May primaries and stressed the need for a continuing friendly relationship between the local physician and the candidate for the state legislature in his area. Since there will be a number of new legislators in the Kentucky General Assembly at the next session, it was pointed out that there is a need for new key men.

The Council also discussed legislative action being considered by other state legislatures this year, the status of major national health and medical legislation, and the action taken by the AMA House of Delegates at the June Annual Session.

Special Article

(Continued from page 767)

earnestly solicited nominations to the committee from delegates, constituent associations, component societies and other interested groups and individuals.

Two resolutions on the subject were referred to the Board.

It is noteworthy that in his report to the House, President Rouse stated that "We now have an established Committee on Planning and Development at the AMA level. I hope that every county and state association will likewise make use of a comparable committee, to plan wisely and develop properly the policies and programs needed in the decades ahead—far beyond just the next year."

Members' Disability Insurance Program

The House adopted the report of the Reference Committee on this subject, and referred to the Board a number of resolutions pertaining to it.

The committee's report, as adopted, recommended that the House authorize the Board to make every effort to continue the AMA Members Group Disability Insurance Program with the same premium-benefit structure. It also recommended the following guidelines to aid the Board in negotiating and executing the necessary contracts and in the future operation of the program:

1. The contract should provide ample assurance that disability claimants will be treated equitably and justly.

2. The carrier should guarantee benefits and pre-

miums for a period of at least five years in order to assure the stability of the program.

3. Promotional literature should be approved in advance by the Board or its designee. All measures within the bounds of dignity and ethics should be utilized to promote the program.

4. A continuous ongoing review of the entire program should be maintained. The insureds and other members should be made aware that such a review may reveal in the future the necessity for a revision of the program at the end of the five-year period.

5. Information regarding the operation of the program, its financial aspects and the processing of claims should be available to the Board for review at any time.

6. An AMA Disability Insurance Review Committee should be continued and should provide a mechanism for claims review.

Political Action

Several resolutions were offered to the House questioning whether the administration of government programs is truly carrying out the intent of Congress in its passage of laws. They were combined by the House into one resolution stating "That if legislation is introduced to investigate the activities of the Department of HEW and its executive personnel who are concerned with health matters to determine if the intent of Congress is being carried out, the American Medical Association will provide to such an investigation any information that its Board and councils may secure in these matters."

The resolution also pointed out that since the most effective method to preserve the private practice of medicine is to elect proper officials at all levels of government, "the American Medical Association urges that physicians, as individuals, redouble their efforts in political activities."

It was also resolved that the Association "continue and expand its efforts to inform our membership of its activities and represent them, particularly before the Congress and the federal agencies."

The House also adopted a resolution "That medical societies be urged to investigate, document and report to the Law Division . . . all violations of Public Law 89-97 by officers or employees of the federal government" and that "a status report be provided to this House at the 1967 Clinical Convention."

The House also reaffirmed the Association's opposition to S. 260 (the Hart Bill) and its support of direct billing under Part B of medicare on the basis of a physician's itemized statement of charges.

The House supported AMPAC and the state PAC organizations by adopting a resolution recognizing "that leadership at all levels of medicine should make individual commitment to state PAC-AMPAC membership and local PAC programs, wherever this is legally possible."

Generic Prescribing

A resolution combining several state resolutions was adopted by the House, asserting "that the AMA again reaffirm its policy that physicians should be free to use either the generic or the brand names in

(Continued on page 818)

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for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
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The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide . . . . . 195 mg.
Aminophylline . . . . . 130 mg.
Phenobarbital, Caution: May be habit forming . . . 21 mg.
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FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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Sick, and worried sick



Professionally posed



Anxiety and tension stemming from organic illness may undermine your patient's cooperation and possibly retard success of primary therapy.

If his emotional symptoms persist in the face of your counsel and reassurance, you may want to consider adjunctive use of SERAX (oxazepam). It is indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression. May be used in a broad range of patients, usually with considerable dosage flexibility.

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10,15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax®
(oxazepam)

Wyeth® SERVICE TO MEDICINE

Wyeth Laboratories
Philadelphia, Pa.

(Continued from page 815)

prescribing drugs for their patients; and encourage physicians to supplement medical judgments with cost considerations in making this choice."

Other Actions

During the convention, the House welcomed 15 physicians who have served in the Volunteer Physicians for Vietnam program; conducted a memorial service for 27 members of the House and/or officers of the Association who had died since the 1965 Annual Convention; heard a report on AMPAC from Blair J. Henningsgaard, MD, chairman of the AMPAC board; heard a report on AMA-ERF from Immediate Past President James Z. Appel, MD, President of AMA-ERF; permitted a representative from the Oregon Woman's Auxiliary to introduce to the House the "Doctor's Wife," a new rose developed by the Oregon auxiliary; and heard a talk by David Kindig, president of the Student American Medical Association.

Adopted many other resolutions, including these:

Amending the bylaws so that recipients of the Ditinguished Service Award and the Citation of a Layman for Distinguished Service will be nominated at the Clinical Convention and the presentations will be made at the next Annual Convention.

Confirming that there is nothing in the military officers' oath that conflicts in any way with the ethics of the medical profession.

Noting that a double standard of policy often exists between so-called "hospital-based specialists" and other types of practitioners with respect to hospital staff appointments and endorsing the principle of a single standard with respect to staff appointments among all physicians having equivalent credentials in all hospital departments and services as a means of assuring maximum freedom of choice of physicians by patients, and of consultants by staff members."

Requesting the JCAH to "encourage . . . the acceptance, wherever possible, of physicians elected or appointed by the medical staff to the Board of Trustees with full voting rights as the most effective form of liaison between the medical staff and hospital governing authorities."

Opposing the establishment of a racial quota system for hospitals.

Encouraging farm equipment manufacturers to establish standards for basic overturn protective frames and crush-resistant cabs.

Reaffirming the Association's policy regarding tobacco and health and promising vigorous continuation of its measures for corrective action.

Urging that disposable hypodermic syringes be thrown away in such a way as to prevent their possible re-use.

Election of Officers

Dwight L. Wilbur, M.D., San Francisco, Calif., was named President-Elect, in which capacity he will serve for one year until his installation as the Association's 123rd President at the next annual convention in June, 1968.

Malcom E. Phelps, M.D., El Reno, Okla., was elected Vice President; Walter C. Bornemeier, M.D., Chicago, Ill., was re-elected Speaker of the House; and Russell B. Roth, M.D., Erie, Pa., was re-elected Vice Speaker.

Four members of the Board of Trustees were elected to succeed themselves. They are Wesley W. Hall, M.D., Reno, Nev.; Irvin E. Hendryson, M.D., Denver, Colo.; Alvin J. Ingram, M.D., Memphis, Tenn.; and Robert C. Long, M.D., Louisville, Ky.

Edward R. Annis, M.D., Miami, Fla., was elected to complete the term on the Board of the late Homer L. Pearson, M.D., Miami, Fla., and Burt L. Davis, M.D., Palo Alto, Calif., was elected to complete the term vacated by the resignation of President-Elect Wilbur.

Maternal Mortality

(Continued from page 746)

by section when the presenting part failed to descend lower than -1 station. It was thought that had a low cervical section been performed any infection might have remained retroperitoneal, and that a patient with ruptured membranes and a prolonged second stage of labor of three hours was not a good candidate for an elective appendectomy.

PHYSICIAN

An Exciting New Career in

The Health Field

Dynamic Internist or Pediatrician needed to serve as Medical Director for the Louisville Neighborhood Health Center. This program is part of the new concept for delivering comprehensive health services funded by the Office of Economic Opportunity. The Director will supervise a professional staff of 36 persons and will be involved in all of the new and interesting facets of this exciting program.

Salary . . . $22,500-$27,000 plus, with fringe benefits and potential for advancement.

Curriculum Vitae for: Dr. Harvey Sloane
Project Director
Neighborhood Health Center
1817 South 34th Street
Louisville, Kentucky

An Equal Opportunity Employer

KMA Receives Names Of Officers From County Societies

The KMA records office had received the following list of 1967 county society officers as of July 20.

Fayette

President: John F. Berry, Jr., M.D., Lexington
President-Elect: David B. Stevens, M.D., Lexington
Vice-President: Gordon Hyde, M.D., Lexington
Secretary-Treasurer: Richard B. McElvein, M.D., Lexington
Delegates to KMA: Andrew Moore, M.D., Lexington
Carl Fortune, M.D., Lexington
David Hull, M.D., Lexington
Irving Kanner, M.D., Lexington
Richard Floyd, M.D., Lexington
John F. Berry, M.D.
Leslie W. Blakey, M.D., Lexington
N. Lewis Bosworth, M.D., Lexington
Thomson R. Bryant, Jr., M.D., Lexington
John E. Myers, M.D., Lexington
Joseph Saunders, M.D., Lexington
Robert Shepard, M.D., Lexington
Alternates: Richard B. McElvein, M.D.
W. Lloyd Adams, M.D., Lexington

Franklin

President: William A. Johnson, M.D., Frankfort
President-Elect: James T. Ramsey, M.D., Frankfort
Secretary: Sandford L. Weiler, M.D., Frankfort
Delegates to KMA: Harry Cowherd, M.D., Frankfort
Sandford L. Weiler, M.D.
Alternates: Harold J. Johnson, M.D., Frankfort
Carl E. Shroat, M.D., Frankfort

Graves

President: Hilary L. Hunt, M.D., Mayfield
Vice-President: Harry M. Roach, M.D., Mayfield
Secretary-Treasurer: Larry Hall, M.D., Mayfield
Delegate to KMA: Larry Hall, M.D.
Alternate: James S. Robbins, M.D., Mayfield

Greenup

President: C. B. Johnson, M.D., Russell
Vice-President: Virgil Skaggs, M.D., Russell
Secretary-Treasurer: C. I. Haeberle, M.D. Russell
Delegate to KMA: John O. Jones, M.D., Flatwoods
Alternate: J. G. Boggs, M.D., Russell

Jessamine

President: V. C. Gillispie, M.D., Wilmore
President-Elect: V. C. Gillispie, M.D.
Secretary-Treasurer: J. Sankey Williams, M.D., Nicholasville
Delegate to KMA: J. Sankey Williams, M.D.
Alternate: Dale Dunkelberger, M.D., Wilmore

Larue

Delegate to KMA: Marion Douglas, M.D., Magnolia
Alternate: J. W. Bradbury, M.D., Hodgenville

Dr. Meulling Named Lab Director

Rudolph J. Muelling, Jr., M.D., former director of the University of Kentucky's division of legal medicine and toxicology, has been named director of laboratories at St. Francis Hospital, Wichita, Kansas. Doctor Muelling had been at the University of Kentucky since 1961.

NEWS ITEMS

Rudolf J. Noer, M.D., Louisville, was re-elected president of the board of the Louisville Philharmonic Society, Inc., recently. The Society operates the Louisville orchestra.

J. R. Buckles, M.D., is now practicing in association with A. L. Embry, M.D., at Millwood. Doctor Buckles graduated from the University of Louisville School of Medicine in 1966 and completed his internship in Florida earlier this year.

Peter C. Campbell, M.D., has recently opened an office in Louisville, limiting his practice to ophthalmology. Doctor Campbell graduated from the University of Louisville School of Medicine in 1961 and recently completed his residency training at Louisville General Hospital.

J. M. Stevenson, M.D., a former member of the KMA Board of Trustees, was honored by the Brooksville Lions Club for 50 years of practice in that city at a dinner June 12. Doctor Stevenson received a plaque from the Club and a Kentucky Colonel Commission from the Governor.

Oscar Allen, M.D., Beaver Dam, was recently honored as the first Ohio County Senior Citizen of the Month by the Ohio County Committee on Aging. Doctor Allen has practiced for 62 years.

Marlow R. Harston, M.D., a Provo, Utah psychiatrist, was recently named executive director of the Western Kentucky Regional Mental Health-Mental Retardation Board, according to W. Ben Humphreys, board chairman.

R. W. Robertson, M.D., and Burton Haley, M.D., physicians to the athletic squads of Paducah-Tilghman School, were given special awards at the school's all-sports banquet May 16 in appreciation for their services to the Tilghman athletic programs.

J. Leland Tanner, M.D., a retired Henderson physician, was appointed full-time health officer for Henderson, Union and Webster Counties July 1, according to a recent press report.

The Soldiers' Home, Bennington, Vermont, the nation's first state operated nursing care facility for veterans to be built with the Federal government absorbing nearly half the cost, was dedicated May 21.

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

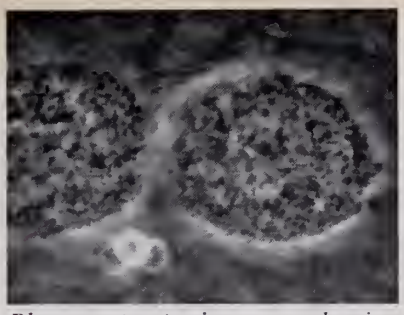


Visual evidence of how corticosteroids influence the inflammatory reaction

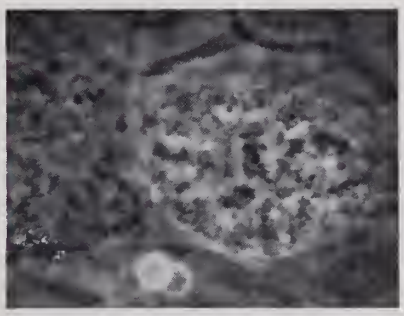
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



Phase-contrast microscopy showing mast cell before injury.



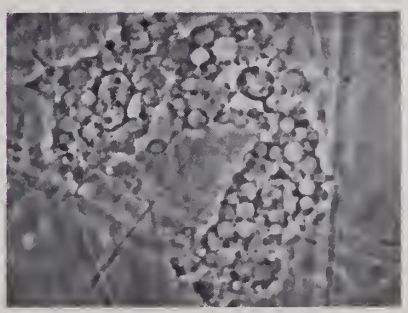
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid —Synalar (fluocinolone acetonide)— the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



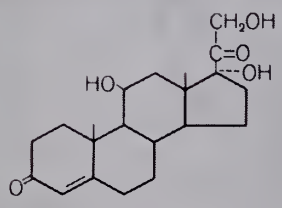
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses*, a film based on this study, is now available from your Syntex representative.

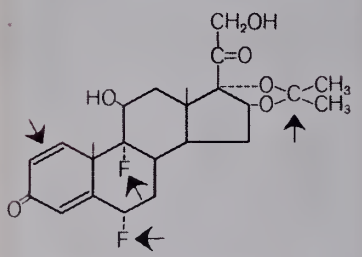
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

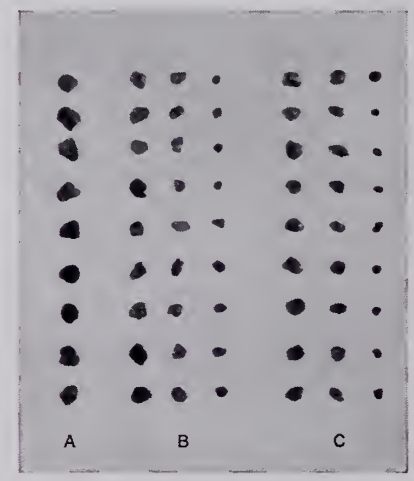


Fluocinolone Acetonide (Synalar)

- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Bonnan, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide—an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory dermatoses... by any measure a topical corticosteroid of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards



when he just can't sleep

Tuinal®

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules®



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

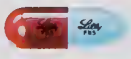
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

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Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, hallucinations); changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

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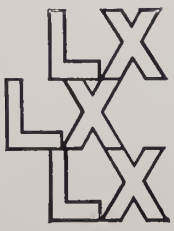
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There are tremendous increases in the demand for medical services brought on by a public more informed on medical progress, more governmental health programs, and a more affluent society. Some have estimated that the individual patient sees his physician 35% more frequently now than a few years ago. This increased patient-load has placed roadblocks in the path of the physician seeking to improve his medical knowledge and his quality of medical care.

Thus the public is becoming more demanding of the physician's time as well as expecting him to keep thoroughly abreast of medical advances. Time for reading scientific journals has been reduced to a minimum. His task of providing good medical service has become a monumental undertaking, not to mention the reams of paper work necessary to certify and verify that the treatment he has administered conforms with the latest knowledge.

More and more there is discussion of the relicensing of physicians and the recertification of specialists by their various boards at periodic intervals. Whether this becomes voluntary by the profession or compulsory by the government depends upon the response of medicine. Your association now has a committee studying the utilization of educational television so that it can be started as soon as the state-wide program is instituted in Kentucky.

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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page



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Brief Summary

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Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

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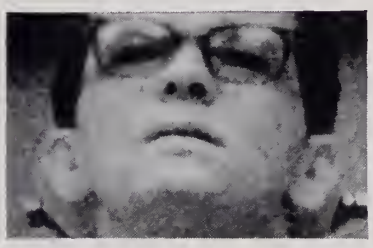
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Please see opposite page for important prescribing information.





PUBLIC HEALTH PAGE

A Program For Referral Of Selective Service Rejectees†

Russell E. Teague, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

SINCE late 1965, the Department of Health in cooperation with the United States Public Health Service has been conducting a health counseling, referral and follow-up for Armed Forces medical rejectees. This program constitutes a major effort to improve the health status of young men now being rejected in appallingly high numbers as medically unfit for military service. Approximately 24 per cent of Kentucky's youth fail military medical examinations for a variety of physical and psychiatric conditions, many of which are responsive to medical attention. Participation is entirely voluntary on the part of the rejectees and over 85 per cent willingly accept program services.

The men are interviewed at the Armed Forces Examining and Entrance Stations by counselors right after the results of the examinations and their defects are known. The importance of medical care is emphasized and the rejectees are encouraged to utilize intensive counseling and referral services available through county health departments. Case histories are prepared on the rejectees, and those that are qualified for referral are forwarded to their local county health department. Upon arrival in the county the cases are screened by the public health staff to determine the action needed in each case. Letters, telephone calls and home visits are utilized in attempts to contact the individual.

Once contacted the public health nurse discusses the man's defects with him or his family and again emphasizes the importance of medical care as soon as possible. The nurse is aware of the health resources available in the community, and the rejectee is directed to the proper resource. The primary resource in any community is the private physician and in most cases this is the one utilized. But many areas throughout the state are without the services of the private physician, and other resources such as vocational rehabilitation, lodge or service organizations and the county health department itself are utilized.

Cases are kept open up to six months to insure that the rejectee has been given ample opportunity to receive care. During this time the nurse keeps in contact with the man and his doctor in order to record progress.

The Armed Forces Medical Rejectee Program's biggest need and future goal is to provide care for those who can't help themselves. It is hoped that with the coming of comprehensive health planning the idea of the Armed Forces Medical Rejectee Program can be broadened to include the large percentage of the population that is missed at present.

From July 1, 1966 to June 30, 1967, 6,500 Kentucky medical rejectees were interviewed at Armed Forces Examining and Entrance Stations in Kentucky, Ohio and Tennessee. Of these, 1,761 were found to be under documented care. No further care was indicated for an additional 1,237. Medical rejectees receiving counseling, referral and follow-up services from their county health departments totaled 3,502 during this period.

Through the Armed Forces Medical Rejectee Program many young men are under the care of a physician for the first time in their lives. Across the state many skilled and dedicated men and women in both public and private service are contributing greatly to the progress of this program. The overall picture in Kentucky is improving. For the future a greater investment of time, money and people is needed to strengthen the health of the state's greatest resource for the future—its youth.

†*This article was prepared by Norman B. France, Coordinator Health Referral Program, Armed Forces Medical Rejectees, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky 40601.*



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

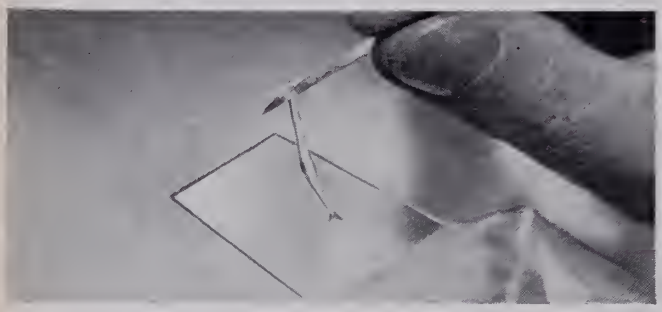
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

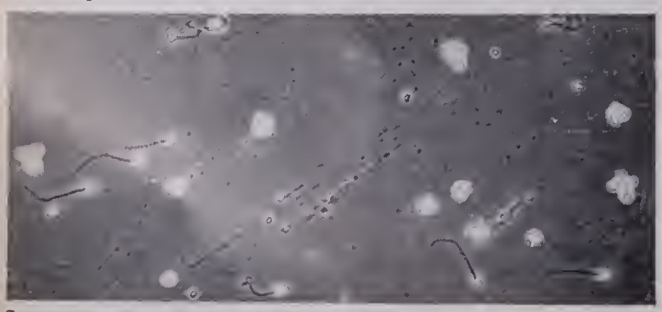
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

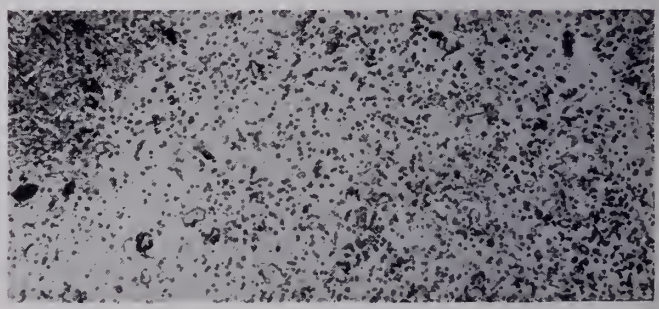


Spermatozoa appear healthy, are active and freemoving.

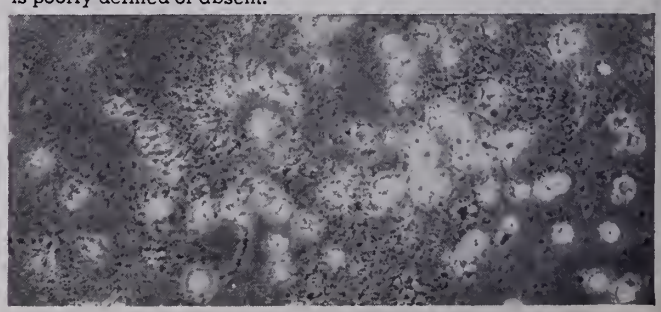
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



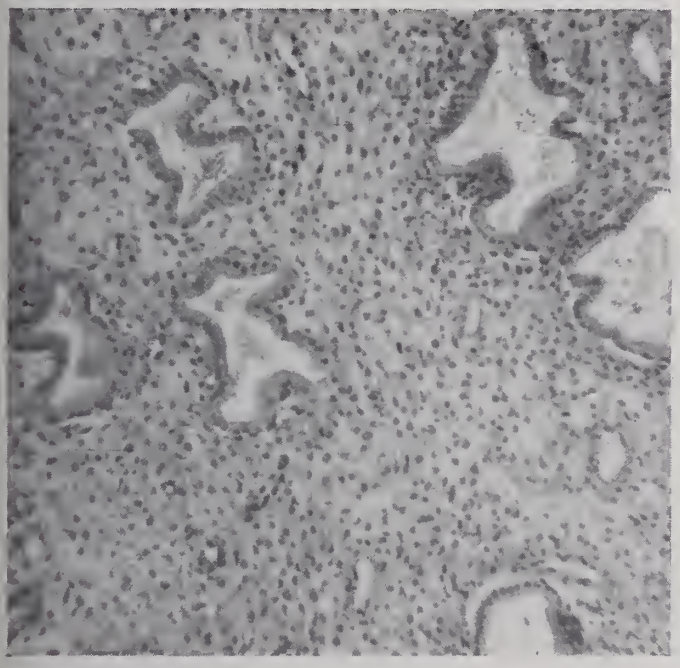
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

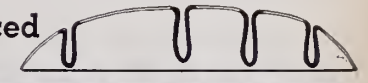
Endometrium of untreated patient

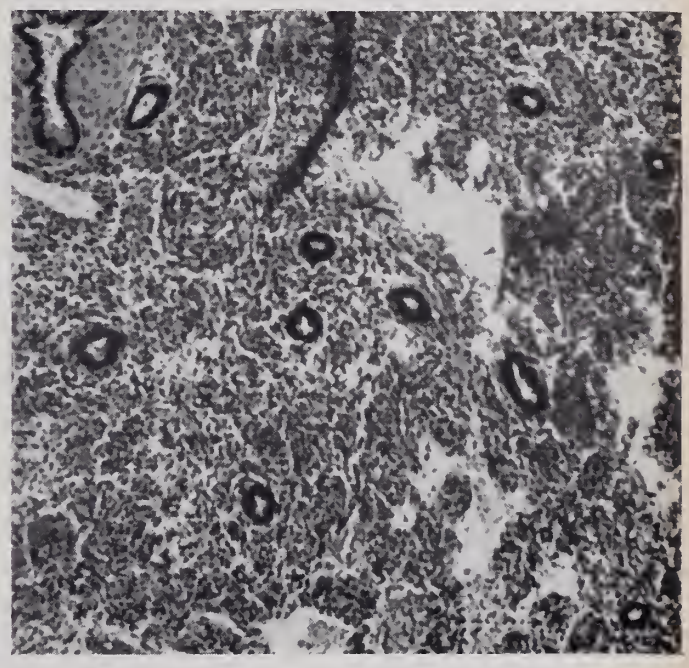




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl-1® tablets
(norethindrone 1mg. c mestranol 0.05mg.)

See last page for contraindications, precautions, side effects and dosage.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

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(norethindrone 1mg. c̄ mestranol 0.05mg.) **tablets**

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

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The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

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Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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IN KENTUCKY

SEPTEMBER

16 American College of Physicians (Kentucky Regional, Stouffer's Inn, Louisville

24 Kentucky State Medical Assistants Workshop, 9 a.m., Statler-Hilton Motel, Covington

26-28 KMA ANNUAL MEETING, Convention Center, Louisville

28 Kentucky Society of Internal Medicine, Louisville

29 Second Oral Cancer Symposium, "Special Problems in Oral Cancer," 9:00 a.m. to 12:30 p.m., Rankin Amphitheater, General Hospital, Louisville

OCTOBER

11-12 Conference on Infections Control in Hospitals, U of L University Center Building, Bigelow Hall, Louisville

19-21 Southeastern Chapter, Society of Nuclear Medicine, Phoenix Hotel, Lexington

NOVEMBER

17-18 Kentucky Thoracic Society, Fall Case Conference, Boone Tavern Hotel, Berea

IN SURROUNDING STATES

SEPTEMBER

7-9 American Association of Obstetricians and Gynecologists, Hot Springs, Va.

15-23 American Academy of General Practice, Dallas

16-17 American College of Physicians (Indiana Regional), Stouffer's Inn, Indianapolis

18-21 19th Annual Scientific Assembly, American Academy of General Practice, Dallas

21-23 "Cardiopulmonary Problems in Children," American College of Chest Physicians Postgraduate Program, Holiday Inn, Chicago

21-23 American Association of Medical Clinics, The Drake, Chicago

25-26 27th Annual Congress on Occupational Health, Atlanta

28-30 American Association for Surgery of Trauma, The Drake, Chicago

29-Oct. 3 American Society of Anesthesiologists, Las Vegas

OCTOBER

2-6 American College of Surgeons, Conrad Hilton, Chicago

6-7 American College of Physicians (Tennessee Regional), Rivermont Holiday Inn, Memphis

11-12 Indiana State Medical Association, Murat Temple, Indianapolis

12-13 "Head and Neck Radiology Conference," University of Illinois Medical Center, Chicago

14-20 Annual Otolaryngologic Assembly, Illinois Eye and Ear Infirmary, Chicago

21-26 American Academy of Pediatrics, Washington Hilton, Washington, D.C.

29 American Association of Ophthalmology, Palmer House, Chicago

NOVEMBER

6-10 "Clinical Cardiopulmonary Physiology," American College of Chest Physicians Postgraduate Program, Knickerbocker Hotel, Chicago

6-17 Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary, Chicago

8-9 Cleveland Clinic Educational Foundation postgraduate course. "Problems in Pelvic Surgery," Bunts Auditorium, Cleveland

13-17 "Diagnosis and Treatment of Diseases of the Heart and Lungs," American College of Chest Physicians Postgraduate Program, Barbizon-Plaza, New York City.

15-16 Cleveland Clinic Educational Foundation postgraduate course, "Pain: Neurological and Neurosurgical Aspects," Cleveland

26-29 American Medical Association's Clinical Convention, Astro Hall, Houston

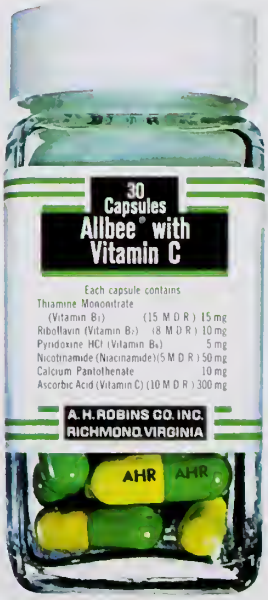
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phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.

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- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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The JOURNAL of the
Kentucky Medical Association

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VOLUME 65 September 1967 No. 9

The Emotional Problems of Aging†

Irving A. Gail, M.D.*

Lexington, Kentucky

"The Emotional Problems of Aging" begin at birth. Rejected, displaced and beset with guilt, the aged regress into dependent status. Subject to somatic diseases, emotional complications are frequent. Careful evaluation and prompt treatment are essential.

BEGINNING at birth to start the normal life cycle, aging is a continuing socio-bio-psychological process. The infant passes from dependency into childhood and adolescence, to experience rapid growth and development. He integrates genetic endowment and develops experiential learning potentialities, which help solve problems of later life. With the introjection of morals and ethics, conscience and awareness, he passes into mature adulthood, expressing patterns of adaptation to maintain purpose and mastery in meeting the stresses of internal striving and external demands. In the normal course of events, patterns so developed and the personality emerging remain the essential functional modality throughout the life of a given individual. These factors coupled with organic changes blend into the aging process.

In the human species the aged are dependent upon the culture of their group. Their fate varies from revered respect to virtual abandonment and death in different cultures. In our American culture, with the impact of rapid change, mobility, technology, family dispersion and youth worship, the aged are made aware of their shrinking dimensions. As the victims of displacement from a central familial position, isolated by illness or death of loved ones, suffering loss of economic security, social status, community membership and threatened by the ambitions of competitive youth, the aged seek solace and refuge in the shelter of their psychological processes. They seek to survive by mustering efforts to reassert status and control, using mechanisms such as projection, denial, or regression and at times over-compensating to their own embarrassment.

In spite of social advances, aging is resisted and denied. We tend to regard aging as a process of dissolution and deterioration. In this framework we witness a great population explosion which includes almost 20 million people 65 years of age and older. These senior citizens face grim prospects, for they are granted token toleration, but denied full acceptance. Why? Because we are threatened by this image. Our self-concept tends to reject the reality of our own vulnerability. It is difficult for us to entertain an identification with deterioration and death without feeling threatened. We shy away from such unpleasant relationships and flee into avoidance.

Because significant physical changes are manifest at the age of 65, this becomes a time of emphasis and identification with aging. Physical slowing down becomes apparent and opportunities for self-expression, socially and in industry, begin to shrink. The government

†*Presented at the Twelfth Annual Clinical Conference, Lexington Clinic, March 30, 1967*

**Associate Professor, Clinical Psychiatry, University of Kentucky Medical Center; Private Practice of Psychiatry, Lexington, Ky.*

and industry tend to retire employees at this landmark of age. We are well acquainted with the rapid deterioration of individuals within periods of months of their compulsory retirement. Preparation for this experience has been lacking and the consequences have been literally fatal.

Whereas the infant passes from dependence into self-assurance and independence, the aging surrenders independence for dependency, loses self-assurance, senses his increased deficiency and shrinks in self-esteem and social significance. The sociological phenomenon of disengagement ensues. Society withdraws from the individual and the aged retreats from society into an introspective life review. He blunts his perceptive capabilities and withdraws further and further into his reverie. Physical impairments related to hearing and vision register not only functional but also psychological deficiencies. The past becomes attractive; glorified reminiscences flourish and the ego is sustained by the recall of exaggerated achievements and satisfactions. In this idle way the painful present is denied. Fantasies preoccupy the mind and wander further from reality. In this experience one doesn't face the transition from the upright posture to a kyphotic stoop, the loss of grey thinning hair, defective vision, impaired hearing, shrinking tissue, strength, brittle bones, decreasing libido, faulty circulation and melancholia.

It is to be noted that this sad portrait is not the fate of all citizens of 65 and over. Chronological age is not the primary factor of functional efficiency. Multiple examples of high level achievement are recognized in the upper age group. Statesmen, educators, legislators, industrialists and physicians function successfully in their latter years. They are unique in sharing a common privilege of higher education, superior economic social status, opportunities for self-expression, satisfaction in careers and esteem in the eyes of society. It is common knowledge that these advantages being absent, others suffering poor social economic status, poor housing, limited education, lack of opportunity and depressed self-esteem comprise a group which yields a heavy harvest in mental illnesses in later years.

This realization should alert us to the challenge of preventive psychiatry. Initial admission to mental hospitals is composed of a large percentile of the 65 and older age group citizens. This is indeed a sad commentary, when we believe that more than half their number would not require hospitalization were they afforded treatment at home or in local facilities during the brief acute episodes which precipitate commitment. Commitment in this age group is particularly to be deplored, for life expectancy within the state hospital is of poor prognosis.

Somatic diseases are frequent and tend to recur in the older population. Degenerative diseases appear; illnesses of earlier onset become manifest; chronic disabilities become incapacitating. These phenomena are frequently associated with depression, irritability, hostility and narcissistic demands. This pattern of reaching out for help and attention creates unpleasant environmental tensions which are usually solved to the disadvantage of the aged sick. When the patient is beset with fear, confusion and helplessness, problems of disposition may be too expeditiously resolved in pre-mature isolation.

With the decrease in new learning ability and the confrontation with new demands and decision making, the aged may experience disorganization of judgment and controls. This may become manifest in frustrated acting out, rages, tantrums, sulking or complete withdrawal into an acute psychotic break. The abrupt onset signals a regression from adequate capability to a dependent, more immature developmental phase of behavior which protects the patient from decision making and continued exposure to stress. This circumstance occurs frequently when collateral support in interpersonal relationships have been dissolved by separation via death, rejection or withdrawal. Although no brain damage is present and the prognosis is considered favorable with the removal from crisis, a precipitous decline may occur, for it is well established that an emotional affront may precipitate physiological decompensation as in heart attack or stroke.

Maladjustments in later age may represent a lessening in behavior controls and an increasing tendency towards impulsive behavior. Controls weaken and the aged become susceptible to perverse or anti-social behavior. While exhibitionism and autoeroticisms are not uncommon among older men, rape tends to be a crime of young men. Few men arrested for forcible rape are over the age of 40. In the aged, regression to an earlier psycho-sexual

phase of developmental behavior may explain the lessening of social restraints. Their involvement in forgery, stolen property and embezzlement contrasts with the aggressive crimes of youth. Their selective activity indicates an ability to evaluate roles, but reflects upon their controls. I will not venture to interpret their participation in anti-social behavior, but we may rationalize the deviation to be an expression of psychological deficit.

It has been pointed out that mental illness in older persons may be the side effect of somatic illness. For example, infectious disease, endocrine disturbance, neoplasm, cardiac decompensation, toxicity, uremia, circulatory impairment and trauma may induce psychosis. Although the remission of mental symptoms may not coincide with improved physical status, treatment of the physiological disturbance offers a favorable prognosis for the confused or hallucinatory syndromes.

While many classifications exist, most patients manifesting mental illness in later years fall into two major categories. One, those who have disorders of affect or content in the absence of brain damage, and two, those who have these disorders in the presence of brain damage. The brain damage syndrome involves disorientation as to time, place and person, impaired concentration, emotional lability, shallow affect, inability to calculate, learn, abstract, faulty judgment, impaired memory recent and remote. However, impairment of recent memory may be a psychological defense shunting out of recall unpleasant associations and stimuli. Mental disorders relating to affect or content in the aged consist of those with endogenous psychosis and the disorders of thinking that appear to develop in later life. In most of these older people the affective agitation or disturbance of thought and behavior may have antedated old age itself.

The Involutional Psychotic Reaction is a depressive or paranoid syndrome without a previous history of manic-depressive reaction. It usually occurs in individuals of compulsive personality type and is manifested by the classical depressive symptoms of worry, anorexia, insomnia, self deprecation, agitation, delusions, hallucinations, and somatic preoccupations.

Psychoneuroses in the aged are common. This group should include the psychophysiological, as well as the anxiety, dissociative, obsessive-compulsive, depressed, conversion and phobic disorders. These persons often merge into the brain syndrome group late in life. Their symptoms become more exaggerated, their depression more severe, and suicide becomes a threat. A detailed history in the affective and thought content illnesses of old age may reveal transient reactions earlier in life. This observation supports earlier treatment as possibly lessening breakdown in old age.

In later years brain syndromes become frequent. Destructive and irritative changes in the central nervous system involving the brain induce changes in patterns of thinking, feeling and behavior. Although there is no clear cut relationship between the degree of organic change to personality functioning, some relationship must exist at least as a release of controls over the pre-existent personality pattern of adjustment.

As you know, related to age changes are:

1. Altzheimer's disease in which gross brain atrophy and nerve cell degeneration appears. This occurs more frequently in females, has its onset in the mid-fifties, is believed of genetic origin and is manifest by gross brain deterioration. It is expressed in hyperkinetic activity and emotional agitation.

2. Pick's disease has its onset in middle age and is believed to be of genetic origin. Affect is blunted, gross brain deterioration precedes death.

3. Cerebral arterio-sclerotic disorders result from the interference of blood supply to the brain. This condition may develop slowly over a long period and symptoms may be slow to appear. However, when abrupt interference of the blood supply occurs, focal signs appear. The patient may have fainting attacks, delirium and convulsions. This syndrome is associated with the organic brain reaction described earlier, referring to disorientation, confusion, memory impairment and poor judgment.

4. Senile brain disease is associated with senile plagues and the presence of brain atrophy. There is a progressive deterioration of intellectual capability and mental functioning. This is commonly referred to as second childhood in which profound irreversible recession occurs. Geriatric psychiatry is giving more thought to multi-factorial causation in mental illness of older paticnts.

An awareness in late life of the inevitability of death may initiate a complete review of one's life's experiences. The task is to integrate one's life as to how it was lived, and how it may have been. The need is to reconcile the past, present and future. The dying faces the pain and discomforts of his final illness, the separation from family and friends and passing into the unknown. Deathbed gifts, promises and forgiveness are supports that make death more acceptable. Accepting life review is an active psychological achievement that yields satisfactions of a life well spent. Although some deny the imminence of death, all need terminal counselling and support. It is there, when the physician is at the bedside. The doctor has magical power to heal in the minds of many sick and aged patients. Their need for help permits a child-parent relationship to develop. The dependent, failing elder bestows parental status upon his doctor and expects him to fulfill parental responsibilities. The physician must be conscious of the temptation to credit himself with those powers. He must understand that the patient's illusions support his needs to get well. The doctor's ability to use these illusions reflects his psychotherapeutic insights.

The physician serves his patient by bolstering his self-esteem, sparing him sympathy, avoiding hasty judgments and demonstrating a willingness to help in all problem areas. He supports their weakened ego without being patronizing, listens patiently to their concerns, gives counsel and lends his strength without the impression of bearing a burden.

Comment

The emotional problems of aging are receiving scant attention in our culture. The individual senior citizen is essentially left to his own resources to contend with his deteriorating socio-bio-psychological status. Needing more assistance than is offered, he regresses defensively into interpersonal disengagement as his supportive fantasies flourish. In the aura of unreality he seeks serenity. What role can the physician play? How can we render unto Senior, that which is Seniors'?

1. Be patient, listen and counsel.
2. Use tranquilizers and sedatives critically, for the elderly are prone to toxic delirium.
3. Offer prompt preventive and therapeutic medicine and surgery, arresting illness early to avoid the emotional concomitant of prolonged illnesses.
4. Avoid precipitous hospitalization, for isolation and strange surroundings may lead to emotional deterioration.
5. Encourage the continuing participation of the elderly in intellectual, social, educational and recreational pursuits.
6. Be aware that the aged patient bestows upon his physician the mantle of wisdom and devotion. WEAR IT WELL!

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Septic Shock In Abortion†

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This paper presents the clinical picture and treatment of endotoxic shock in septic abortions. Prompt diagnosis and aggressive treatment offer the only means of lowering the mortality rate.

SEPTIC shock is now a leading cause of maternal deaths when the death rate, from all other causes, is declining. Weil[22] reports an 18 per cent incidence of septic shock in all obstetric patients with bacteremia. Neuwirth[13] reports an incidence of 6.4 per cent of septic shock in patients with septic abortion. Stevenson,[18] at Detroit Receiving Hospital, reports an incidence of 1.8 per cent. At Louisville General Hospital, between the years 1962 through 1965, there were eight patients with septic shock in 133 cases of septic abortion or an incidence of 5.5 per cent.

The mortality rate, in obstetrical patients with septic shock, varies from 5.5 per cent to 40 per cent.[4, 12, 18, 22] The mortality rate for septic shock, in general, ranges from 20 to 80 per cent. [2, 6, 7, 15, 17]

Pathophysiology

The *sine quo non* of septic or endotoxic shock is the insidious fall of the blood pressure. Although the blood volume may be normal,[9] there is a decrease in cardiac output with a resultant decrease in blood pressure. This decrease in cardiac output is due to pooling of the blood in the hepatic and portal areas.[3] Direct observations and post-mortem studies of dogs have shown there is trapping of blood in the splanchic and hepatic areas. The liver becomes enlarged and congested.[6] Indirect evidence points to splanchic pooling in humans.[11] The basic process is a severe vasodilation with ischemia and pooling of the blood (Table I).

The intense vasoconstriction results in inadequate perfusion of the tissues with consequent anaerobic metabolism (Table II). This causes an accumulation of lactate and pyruvate which is a reflection of the tissue oxygen deficit. Ultimately, this leads to metabolic acidosis. Besides the local tissue acidosis, the decreased kidney perfusion increases the acidotic load.

TABLE I

Endotoxin → severe vasoconstriction (ischemia) → vasodilatation → pooling of blood in hepatic and portal areas → ↓venous return to the heart → ↓cardiac output → profound hypotension.

The acidosis depresses myocardial contractility, and the catecholamine response of the peripheral blood vessels. Thus, acidosis leads to myocardial failure, peripheral vascular collapse and ultimate death.

Case Histories

The ages of these eight patients ranged from 17 to 37 years (Table III). They were two to five months pregnant. Three patients presented with the chief complaint of "bleeding", two with "pain", two with "miscarriage", and one with "weakness". Two patients admitted to a criminal abortion "this time", and one stated that she had a criminal abortion three months earlier with another pregnancy. Six of the eight patients admitted to some fever and chills with

TABLE II

Endotoxin → severe vasoconstriction → inadequate perfusion of tissue (anoxia) → a) ↑in lactate & pyruvate, b) ↓in kidney perfusion → metabolic acidosis → a) ↓myocardial contractility, b) ↓blood vessel response to epinephrene → peripheral vascular collapse → death.

†*This paper was presented in the Fall of 1966 at the District V meeting of the Junior Fellows of the American College of Obstetricians and Gynecologists in Louisville, Kentucky*

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TABLE III

CASE	AGE	GR.	P.	AB.	MONTHS PREGNANT	CHIEF COMPLAINT	OTHER RX
1	20	10	5	5	2½-3	"miscarriage"	criminal abortion 2 days PTA, cramps, chills
2	19	4	3	1	5	"weak"	aborted in emergency room 2 days earlier
3	37	9	5	4	3	"bleeding"	two days of bleeding with fever and chills
4	31	4	2	2	4	"fever and hurting"	rubber catheter in uterus four days
5	21	3	2	1	3	"bleeding"	bleeding and cramping, fever one day
6	26	7	3	4	2½	"pains"	spotting, fight with husband
7	17	3	1	2	2	"miscarriage"	spotting, criminal abortion attempt 3 months prior
8	37	10	8	2	3½	"bleeding"	aborted in emergency room

their present illness. Two had just recently aborted.

Pelvic examination revealed that the cervical os usually was open and the uterus was tender (Table IV).

Clinical Course

The woman who is having a septic abortion usually presents with the chief complaint of bleeding and some lower abdominal pain (Table V). Characteristically, the blood loss is small. Many will give a history of fever and chills of 1-2 days and will state frankly that she is having a miscarriage. Most will have nausea and vomiting. The more severe cases will have a very recent onset of diarrhea. With these patients, it is difficult to pinpoint the exact onset of the bacteremia. However, in urologic patients who have been instrumented for one reason or another, the time interval has been averaged at 14 to 16 hours before the onset of the first clinical feature of sepsis.[15, 22] Characteristically, the first sign of bacteremia is a pronounced chill or rigor. This is rapidly followed by fever, nausea and vomiting. The older patients quickly become obtunded or mentally confused; in fact, this is sometimes the initial manifestation.

The examination of this patient may show temperature elevation of 98 degrees to 106 degrees (Table VI). The patient may even be hypothermic. They may appear grossly normal or be critically ill, depending upon the stage of bacteremia and shock. Quite characteristically, the patients are mentally alert and responsive. The warm, dry skin is misleading, and the clinician is unaware of circulatory failure until the blood pressure is measured. The pulse may be slow and bounding or increased to 160 beats per minute. The abdomen is generally tender over the lower quadrants, especially in the area of the uterus. The vagina may contain an odorous, purulent discharge, but more often it does not. The cervix is usually open with blood or placental tissue in the os. Some of the more severe cases have ap-

TABLE IV

CASE	EXAM	HRS. FEBRILE	SPIKE	ONSET SHOCK	DX. OF B. P.	SHOCK WBC	24 HRS. LATER
1	Cx. open; tissue in os, 2½ month size uterus.	12	105°	1 hr. 20 min.	80/50	9,800	28,300
2	Profuse yellow discharge cx. open, boggy uterus.	9	102°	2 hr.	76/50	?	22,200
3	3 month size tender uterus.	72	106°	1 hr.	86/50	5,543	7,980
4	4 month size, soft and tender uterus.	48	106°	30 min.	74/80	11,000	15,700
5	Cx os open, tender uterus.	22	105°	1 hr.	84/50	QNS	10,838
6	Cx. os closed, uterus not tender	3½	105°	2 hr. 15 min.	70/40	5,400	36,852
7	Vagina — much necrotic material, cx. open, tender uterus.	72	105°	6 hr.	40/0	1,100	10,045
8	Cx. os closed, fetus hanging by cord	5½	104°	5½ hr.	0/0	9,400	17,135

peared with a small fetus in the vagina. The uterus usually is 8 to 12 weeks in size and tender. The parametria may be edematous and boggy. The cul-de-sac may be tender, indicating pelvic peritonitis or frank pus present.

If the patient is not treated vigorously, there is an insidious fall of the blood pressure. As the severity of the hypotension increases, the distal extremities, later the ear lobes, and then the tip of the nose, become cyanotic. The skin becomes mottled and has a gray-blue tinge. The patient now is cold and perspiring. Her veins are collapsed. Her cerebral function is diminished, and there is oligurea.

Treatment

In our series, the amount of fever which preceded the onset of endotoxic shock could not be correlated. It varied from three and

TABLE V

HISTORY:
Abdominal tenderness and bleeding; blood loss is small; fever and chills of 1-2 days duration; some nausea and vomiting.

one-half hours to 72 hours. Frequently, the history is sketchy in these cases. Six of the eight patients had a temperature spike of 105 degrees or more (Table IV). The patients were admitted with the temperature spike, or developed it shortly after admission. The passage of the infected abortus or placenta usually heralded the temperature spike. It is important to note that within two hours of this temperature spike, six of the eight patients were hypotensive. The duration of hypotension varied from one to nine hours, with the average being two and one-half hours. The patients were not necessarily at shock levels during this length of time. However, this was the time required to stabilize the blood pressure. The hypotensive episodes were heralded by a precipitous fall in the temperature even to a subnormal level. Usually there is an associated leukopenia with this episode. The white blood count begins to rise four to six hours later, so that at the end of the first 24 hours, there is marked leukocytosis. The hypotension is so insidious that the patient may die while talking with you.

Since the basic problem is overwhelming infection, the treatment should be primarily large doses of antibiotics (Table VII). These infections have been best treated with penicillin and chloramphenicol in large doses. The idea

TABLE VI

EXAM:
Temperature 98° to 106°; blood pressure normal or down. May appear alert or critically ill.
Tender lower abdomen.
Vagina — may have purulent material present, usually it does not.
Cervix — os is usually open.
Uterus — 8-12 weeks size and tender.
Parametria — edematous and boggy.

should be to sterilize the patient completely by perfusing all tissues with a high concentration of antibiotics. These eight patients were treated predominately with intravenous antibiotics. The doses ranged from 10 million to 100 million units of aqueous penicillin per liter of five per cent glucose in water. To this was added one to three grams of cholramphenicol. Once the patient had received a liter of this mixture, the doses were decreased to 30 or 40 million units of aqueous penicillin per liter of five per cent glucose in water every eight hours. These high doses of penicillin will cause some burning at the infusion site.

The steroids were given as soon as the diagnosis of septic shock was made. As these patients were prime candidates, they were watched closely, and the diagnosis usually made at its onset. Earlier in the series, 100 mgm. of hydrocortisone was given intravenously as a stat dose. In the later patients, much larger doses were used. Perhaps this was because we found that hydrocortisone was not particularly injurious and the mortality of the inadequately treated patients was high. The daily dose of steroids was decreased by one-third to one-half each day. It was given intravenously in equal amounts every six hours. Occasionally, the patients became obtunded from the high levels of cortisone. Frequently, the Cushingnoid or "moonface" was evident. Because they were on high doses for several days, the withdrawal of a steroid was gradual. One patient was on hydrocortisone for 17 days. Near the end of the withdrawal, four of the patients received 20 units of ACTH for three days. Usually the patients were kept on a dose of 30 million units of aqueous penicillin every eight hours until the hydrocortisone was under 100 mgm. a day.

Five of the eight patients were transfused with blood initially, and all received three liters of five per cent glucose in water daily. If fluids are given rapidly to bring up the blood pressure, it is important to monitor the central

TABLE VII

CASE NO.	HYDROCORTISONE STAT DOSE	HYDROCORTISONE FIRST 24-HR.	DAYS DURATION	ANTIBIOTIC IN 1 LITER D_5W	BLOOD	ARAMINE	ETIOLOTY
1	100 mgm	200	1	10 mil. aq. penicillin, 1 gm chloromycetin	0	0	Proteus
2	350 mgm	800	6	5 mil. aq. penicillin, 0.5 gm. chloromycetin, streptomycin 1 gm. IM	0	0	Nonhemolytic Staphylococcus
3	1400 mgm	2900	8	2 gm. chloromycetin 1.2 gm. sulfadiazine	0	27 hr.	Hemolytic Staphylococcus
4	400 mgm	1900	13	70 down to 40 mil. aq. penicillin, 1 gm. chloromycetin	2 pt.	16 hr.	None
5	900 mgm	2700	17	60 down to 40 mil. aq. penicillin, 2 gm. chloromycetin	1 pt.	20 hr.	None
6	800 mgm	2600	16	1 gm. tetracycline, 4 gm. chloromycetin	1 pt.	38 hr.	E. Coli Hemolytic Staphylococcus
7	2000 mgm	5000	15	50 down to 30 mil. aq. penicillin, 3 gm. chloromycetin	2 pt.	7 hr.	Klebsiella
8	2000 mgm	9500	11	100 down to 40 mil. aq. penicillin, 3 down to 2 gm. chloromycetin	3 pt. 1st 6 hr.	0	None

venous pressure as the onset of pulmonary edema or cerebral edema may be quite insidious. Although blood is not generally indicated in septic shock, sound judgment may deem it beneficial. Five of the eight patients were given the vasopressor metaraminol. It was used when blood pressure could not be sustained by fluids and steroids alone. This should be used to keep the blood pressure high enough to adequately perfuse the kidneys. The kidney is the most sensitive organ effected in endotoxic shock. The pressure for adequate perfusion may be only 80 or 90 mm. of HG. It is usually much below the preshock levels. The pressure should be just high enough to cause adequate urinary output. Hourly measurements of urine were done. If the blood pressure fails to rise or there is oliguria, then acidosis may be present, and it should be corrected. Phenoxybenzamine might aid in perfusing the kidneys. It was not used in our series.

Daily electrolytes were normal in this series. Metabolic acidosis was not seen. This was because of the prompt diagnosis and effective treatment.

At this hospital, the index of suspicion is high, and likely candidates for endotoxic shock are treated so vigorously with antibiotics that we use the term "septic shock without shock". If the blood pressure falls, then the diagnosis of septic shock is made and steroids are given.

It is difficult to get the surgeon to operate on these critically ill patients. Fortunately, laparotomy or hysterectomy was not necessary in these eight patients.

As a followup, several of the patients have had children without difficulty. One patient had two more episodes of septic abortion but without septic shock.

Discussion

Antibiotics: In endotoxic shock, the cause is sepsis. Immediate cultures of blood, urine and endometrial cavity should be done. Massive doses of antibiotics should be given intravenously. The ultimate survival of the patient may depend upon the proper choice of antibiotics. However, if one waits for his culture reports in a patient with septicemia, he will rarely have a live patient available for treatment. Theoretically, the severity of the shock may be intensified by the sudden destruction and lysis of the enteric bacteria. This is due to the liberation of more endotoxin. Chloramphenicol in doses of 4 to 6 gm. per 24 hours is usually used. Penicillin is used in doses varying from 20 to 40 million units per liter of 5 per cent dextrose in water. Recent evidence indicates that penicillin may be the most effective drug against gram-negative organisms when given at high doses.[14] Penicillin contains 1.7 mEq of potassium per million units of aqueous penicillin. This has to be considered if the patient is oliguric or has impending renal failure. If the patient does not respond to the

treatment, streptomycin and kanamycin are added.

E. coli is the most common offending organism. Others frequently involved are the Klebsiella-aerobactor organism, Proteus and Pseudomonis.[6, 15, 22] Pritchard[1] and Fernadez[12] believe that gram-positive organisms can produce the same shock-like picture.

Fluid volume: Hopkins[9] reported a normal blood volume in 9 of 11 patients. If septic shock is associated with obvious blood loss, then certainly blood should be replaced. Five per cent glucose in water is the solution of choice if blood is not necessary. Dextran, a plasma expander, should be used as a last resort in an effort to stabilize the blood pressure. Dextran is known to alter coagulation factors. Saline solutions are also unwise if steroids are used because of the marked sodium retention.

The best route for the administration is the cephalic or brachial vein. These are easily accessible and permit a large catheter to be threaded centrally. It can also be used as a monitoring device for central venous pressure. The pressure should be maintained at 6 to 12 cm. of water and should not exceed 15 cm. of water. All too frequently, in an effort to have a blood pressure high enough to move an effective circulating blood volume, the patients are overinfused. Many deaths from acute pulmonary edema have been reported.[5, 16, 18]

Vasopressors: The use of vasopressors in bacterial shock is still the subject of controversy. The systolic blood pressure should be adequate enough to cause urinary output. This may be 80 to 100 mm. of Hg. or 20 to 30 mm. of Hg. below normal. If the blood pressure is less than this, then vasopressors are used. The most common is metaraminal (Aramine). Metaraminol increases peripheral resistance, maintains venous return to the heart and increases cardiac contractility.[21] This then elevates the blood pressure, improves alertness and urinary output, and no attempt is made to bring blood pressure to the "preshock" level.

Steroids: Adrenocortical insufficiency is not the cause of irreversible bacteremia shock. It is not the cause of hypotension. The adrenal cortex continues to produce a high level of hydrocortisone and continues to be responsive to the corticotropins. Actually, measurements of the 17-hydroxycorticoid levels in patients with bacteremic shock are always at the high normal levels. Yet the administration of steroids seems to increase the survival rate. Lillehei[10] has shown that steroids lower the catecholamine level and the peripheral resistance and increase the venous return to the heart and visceral organs.

Still another reason for the use of hydrocortisone may be the so-called Schwartzman reaction or hypersensitivity which occurs as a result of the endotoxin. The purpose then would be to block this allergic reaction.

Steroids are advocated for use, particularly when the blood pressure fails to respond to vasopressors.

The average dose of hydrocortisone is 2,000 mgm. per 24 hours. Hydrocortisone is usually given intravenously. The amount given varies from 200 to 1,000 mgm. intravenously stat. Amounts from 300 to 500 mgm. are given every 30 to 60 minutes. The blood pressure is usually stable after the first one to two hours, unless there is a volume deficit or an uncorrected metabolic acidosis. High levels are maintained by giving 300 to 500 mgm. every six hours for two to three days. They are then abruptly withdrawn. If used longer than 72 hours, it is best to withdraw gradually to zero to prevent an adrenal failure.

Vasodilators: This is currently the newest and most disputed part of the treatment of septic shock. If the basic disease process of endotoxic shock is an overstimulation of the sympathetic nervous system with a resultant intense vasospasm of the arterioles, then here is the need for a vasodilator.

Phenoxybenzamine (Dibenzlene) is a potent, very rapidly acting vasodilator. It is thought to act by inhibiting the action of catecholamines and histamines on peripheral blood vessels.[8, 20] Weil has observed that when phenoxybenzamine is given to animals before the onset of endotoxic shock, there is a better survival rate. There is no difference in survival rate if given after the onset of shock. Martiniz,[12] in a recent work with 18 patients with septic shock, advocates using the phenoxybenzamine before metaraminal. His mortality rate was 5.5 per cent.

Surgery: A dilatation and curettage may be necessary because the antibiotics cannot reach a dead embryo or fetus. Thus, the bacteria are not eliminated by antibiotics and continue to reproduce endotoxin. The patients are treated with large doses of antibiotics for 12 to 24

hours, then a dilatation and curettage is done. However, the operation is done earlier if the patient is not responding to treatment.[4, 19] Fear may prevail that the dilatation and curettage will break down any natural barrier that has already formed within the uterus, and there is also an increased chance of perforating the uterus. General anesthesia is not necessary. The dilatation and curettage can be accomplished quite well under local and paracervical block with lidocaine. If general anesthesia is to be used, it is imperative to get the patient out of peripheral vascular collapse. The amount of tissue obtained is important. If only a small amount of tissue is obtained and the patient is in septic shock, then usually the infection has spread to the parametria. This small amount of tissue obtained may be the tip-off that a hysterectomy is indicated.

Summary

1. Eight patients with septic shock, out of 133 patients with septic abortion, in the past four years at Louisville General Hospital are discussed. There were no deaths.

2. The basic defect is severe vasoconstriction of the peripheral vascular beds followed by dilatation and shock.

3. Shaking chills or rigors are usually the first manifestations of bacteremia.

4. Expelling an infected abortus or placenta initiates the temperature spike.

5. The hypotension is heralded by a sudden fall of the temperature and white blood count.

6. Massive doses of penicillin and chloromycetin with hydrocortisone are the treatments of choice.

7. Venous pressure should be monitored with a central venous catheter if rapid infusion is planned.

8. Steroids potentiate any vasopressor used and may decrease any allergic type reaction.

9. A dilatation and curettage or hysterectomy in critically ill patients may be necessary.

10. Early diagnosis and aggressive treatment give a lower mortality rate.

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Head and Neck Tumors and Maxillofacial Prosthetics†

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The incidence of head and neck cancer is approximately 15 percent and oral cancer 5 percent of all malignant tumors. The treatment of cancer often leaves maxillofacial defects which are rehabilitated with prosthetic devices constructed by a dentist.

CANCER is the second greatest killer in the United States. The early recognition and detection of precancerous and cancerous lesions are essential to conquer this illness.

The dentist, as a member of the health profession, plays an important role in the prevention, the detection, and total rehabilitation of the patient.[1] The patient with pain, headache, dizziness, and swelling of the head and neck areas often seeks first the dentist's help for possible decayed teeth or oral lesion and thus gives the dentist first opportunity to see and examine the patient.

Incidence of Head and Neck Cancer

The incidence of head and neck cancer is estimated at more than 15 percent of all malignant tumors, and the oral cancer represents only 5 percent of the total incidence.[2]

In 1946, statistics shown by Martin at the Memorial Hospital in New York indicated that approximately 60 percent of the patients with cancer of the gums had consulted a dentist first. In a total of 157 cases, the probability of cancer recognized by the dentist was 38 percent, and the elapsed time between first seeing a dentist and first seeing a physician was three and one-half weeks. In the remaining 62 percent, the probability of cancer was not recognized by the dentist, and the elapsed time between first seeing a dentist and first seeing a physician was eight months. As the statistics show, the elapsed time from the first visit to the second is lost time, and the man who has the first opportunity to suspect a malignant growth has the golden opportunity to save the patient's life.[3]

Examination

Special attention and emphasis should be given to examination of head and neck area. Education and preparation of the patient, the lighting of the room and the instruments, the training and the experience of the operator are very important factors. Maxillofacial prosthetist and/or prosthodontist who has had his training in a cancer hospital has developed his senses of sight, feeling, and smell, which are the three main gifts for a good examiner. Examination of the head and neck area is performed in the usual sequence.

Diagnosis

To know the abnormal anatomy, you must know the normal. Any suspicious lesion which is present for two weeks during which time no signs of healing are shown should be biopsied and the specimen sent to a general and/or oral pathologist for microscopic study. It is important that the clinician furnish with the specimen a brief history, the duration of the lesion, description of location, and gross characteristics of the lesion.

It is only after the microscopic study has been made that the diagnosis of a neoplasm can be established. Once the diagnosis is established, treatment should follow without delay, and the patient should be referred to a competent physician or a medical center.

Treatment

1. Removal of the cause—prophylaxis—cause of irritation—vitamins
2. Surgical removal
3. Radiotherapy
4. Chemotherapy

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†*Presented at the first Oral Cancer Symposium, University of Louisville, School of Medicine, Cancer Control Program, U.S. Public Health Service, February 11, 1966.*

**Director of Maxillofacial Prosthetics Clinic, Indiana University, School of Dentistry, Indianapolis*

5. Combination of 1 and 2, 1 and 3, and 1, 2, and 3 or all four
6. Plastic and reconstructive rehabilitation
7. Maxillofacial prosthetic treatment and rehabilitation

Multidisciplinary education is important for the treatment of head and neck cancer. No one doctor can treat alone and rehabilitate the cancer patient. The management of head and neck cancer is a group effort. The maxillofacial prosthetist and/or prosthodontist should be a member of the tumor team. He should see the patient prior to treatment, be available to advise in treating, and in the rehabilitation of the patient; the close cooperation among surgeon, pathologist, radiotherapist, and maxillofacial prosthetist is the measure of the successful cancer treatment. As Doctor Frazell stated at a recent Maxillofacial Prosthetics Workshop in Washington, "Lack of communication with the prosthodontist can cause unnecessary delay in total treatment of the patient."[6]

Maxillofacial Prosthetics

Maxillofacial prosthetics is the art and science of anatomic, functional, or cosmetic reconstruction, by means of non-living substitutes of intra-oral, para-oral, and extra-oral structures that are missing or defective due to surgery, trauma, or developmental or congenital malformations.[7]

Maxillofacial Defects

There are three types of maxillofacial defects:

1. Congenital
2. Developmental
3. Acquired, such as post-surgical, post-pathologic, and post-traumatic defects

Post-surgical Cancer Defects of the Head and Neck Area

To insure the complete removal of cancer, sometimes it is necessary to perform a radical surgery. Sarnat and Schour state, "If the surgeon does not eliminate the cancer, the cancer will eliminate the patient."[8]

Rehabilitation of the patient with post-surgical maxillofacial defect is of prime importance to return him to his society. Rear Admiral F. M. Kyes states at the American Academy of Maxillofacial Prosthetics Workshop that, "Healing and repair should not be entirely on the face, in the mouth, or in the nasopharynx, it must be in heart, mind and soul."[9] Priority should be given to plastic and reconstructive surgery, but prosthetic reconstruction is certainly very effective for cancer patients.

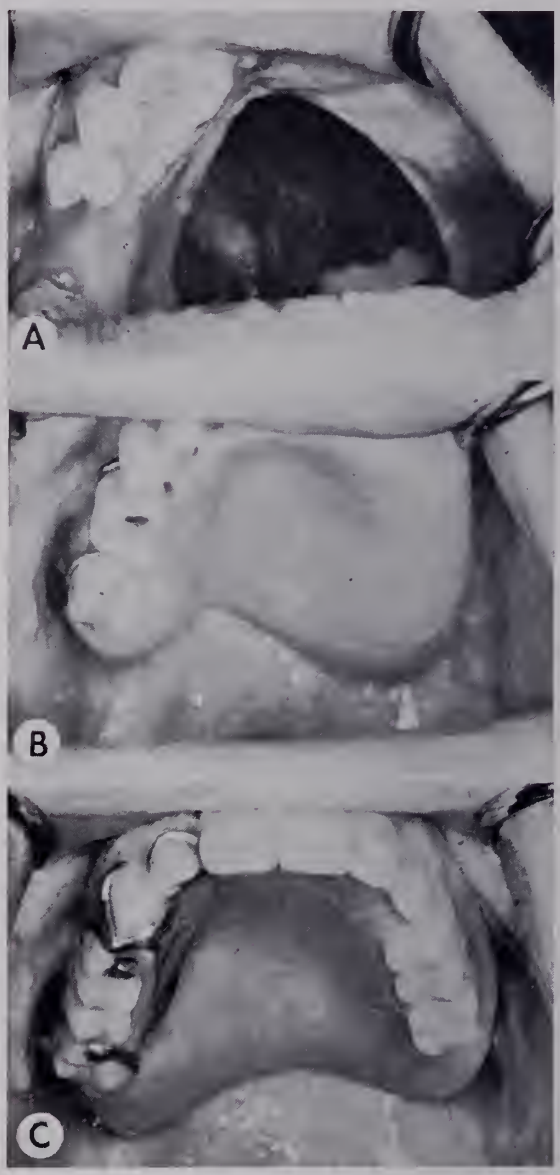


FIG. 1A—Partial resection of left dentulous maxilla for cancer treatment

FIG. 1B—Temporary obturator inserted in the mouth after surgery and retained by wire clasps

FIG. 1C—Permanent obturator inserted in the mouth and retained by cast clasps

Role of Maxillofacial Prosthetics

1. Esthetic
2. Functional
3. Esthetic and functional
4. Protective
5. Healing
6. Psychologic

Major Types of Head and Neck Post-Cancer Defects

1. Intra-oral
   a. Maxilla
      (1) Conservative local excision of soft or hard palate
      (2) Partial resection (Fig. 1A and Fig. 2A)
      (3) Total resection of maxilla
   b. Mandible
      (1) Conservative marginal excision
      (2) Partial resection of mandible
      (3) Hemimandibulectomy
      (4) Total mandibulectomy

2. Extra-oral
   a. Partial or total excision of the nose (Fig. 4A)
   b. Partial or total excision of the ear (Fig. 5A)
   c. Partial excision of cheek tissue
   d. Enucleation of the eye
   e. Exenteration of the orbit (Fig. 3A)
   f. Partial removal of cranial and facial bones

Major Types of Maxillofacial Prosthetics for Cancer and Post-Cancer Treatment—Rehabilitation

1. Intra-oral
   a. Maxilla
      (1) Immediate temporary obturator —surgical prosthesis
      (2) Temporary obturator (Fig. 1B)
      (3) Permanent obturator (Fig. 1C and Fig. 2B)
      (4) Radium needle carrier—and/or protector prosthesis
      (5) Stent
      (6) Splint
   b. Mandible
      (1) Splint
      (2) Stent
      (3) Resection appliance
      (4) Mandibular implants
      (5) Radium needle carrier and/or protection shield

2. Extra-oral prostheses
   a. Ocular
   b. Orbital (Fig. 3B)
   c. Nasal (Fig. 4B)
   d. Auricular (Fig. 5B)
   e. Cheek
   f. Radium protector mask

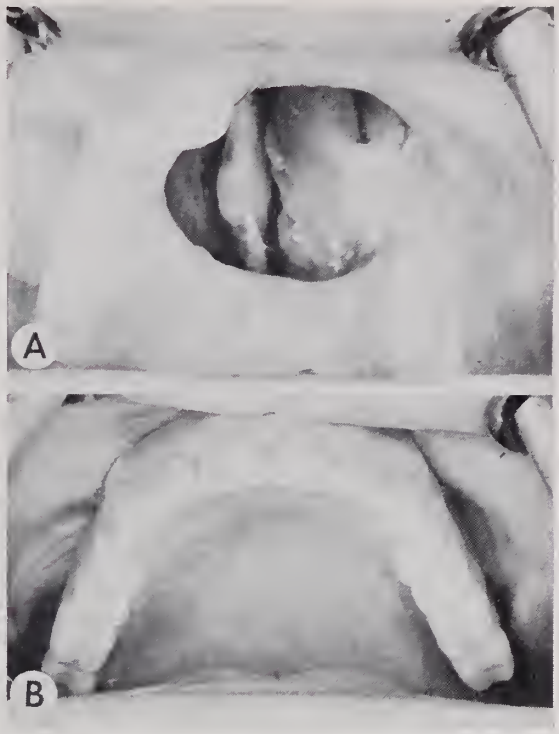


FIG. 2A—Partial resection of left edentulous maxilla for cancer treatment

FIG. 2B—Permanent obturator with false left palate and ridge inserted in the mouth

3. Combination of intra-oral and extra-oral prostheses
4. Cranial and facial bone prostheses

The dentist plays an important role in detection, control, treatment, and rehabilitation of head and neck cancer. Maxillofacial prosthetic restorations can best be accomplished by a dentist because of his understanding of the nature of the materials that may be used, the techniques required, and his artistic skills.

The treatment of patients with post-cancer maxillofacial defects should be done through



FIG. 3A—Exenteration of left orbit for cancer treatment
FIG. 3B—Orbital prosthesis seated over the orbital defect

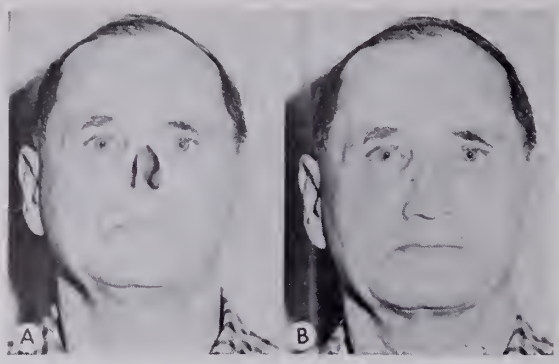


FIG. 4A—Total excision of the nose for cancer treatment

FIG. 4B—Nasal prosthesis seated over the nasal defect



FIG. 5A—Total excision of the right ear for cancer treatment

FIG. 5B—Auricular prosthesis seated over the auricular defect

the cooperation of a team of medical, dental, and allied specialists. The maxillofacial prosthetist and/or prosthodontist should be a member of the hospital staff and a member of the tumor team.

Summary

The incidence of head and neck cancer is approximately 15 percent and oral cancer 5 percent of all malignant tumors. The dentist plays an important role in the control, the treatment, and the rehabilitation of the cancer patient. Accurate examination of extra-oral and intra-oral anatomy and biopsy is important for cancer diagnosis. The treatment of cancer often leaves maxillofacial defects which are rehabilitated with prosthetic devices. Maxillofacial prosthetics is classified as (1) intra-oral prosthesis, (2) extra-oral prosthesis, (3) combined prosthesis, and (4) cranial and facial bone prosthesis.

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Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

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A Building Block approach to treating hypertension

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With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

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A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

ABBOTT

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
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Eutron adds thiazide for enhanced therapy with milder side effects

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

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707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

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Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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SPECIAL ARTICLES

The Role of Organized Medicine†

R. Frank Manegold, M.D.*

IN ORDER "to discuss the role of organized medicine in connection with accreditation and its effect on the quality of patient care," one must define the key terms "organized medicine," "accreditation" and "quality of patient care." I am reasonably certain that there would be some significant differences in each of these definitions. Let me define them with the full awareness that the definitions are certainly open to question.

The organization of medicine is stratified. The basic unit must be the organized medical staff of an institution—most usually a hospital. The next level of organization is the county society, then the state society. Finally, in the pursuit of this logic, there is the American Medical Association. Not to labor the point, a similar arborization could be described for any of the special medical societies. Inescapably, the basic unit of organization of medicine is most typically the hospital medical staff.

Accreditation is defined as the certification by a recognized body, political or other, that certain standards of performance are maintained in an acceptable environment. While one could have good nursing and medical care in a barn, the facilities would hardly be accreditable as a hospital. A felicitous structure does not make a hospital. The issue is who sets the standards, who applies them.

The "quality of patient care" is the toughest one. Is patient care synonomous with medical care? What is quality in this context? We know quality in cars and diamonds, with measurable certainty. We recognize quality in artists, hockey teams, and I believe we recognize it in schools, but we may have difficulty in recognizing and defining what we mean by quality of patient care. A few anecdotes will make the point.

A letter received in my office read as follows:

> I recently was a patient in the hospital and had a lamenectomy and had my chance to be on the receiving end of things.
>
> I am a general practitioner and have had many sleepless nights, and am a light sleeper. I could hear every phone ring, chart rack slam, loose-leaf chart snap, and the name plate machine every night. I grant you these things must be done. I kept thinking of ways I could suggest to eliminate phone rings, etc., only I needed a follow-up of an engineering department to carry out my intentions.
>
> I felt sorry for the people in the Intensive Care Unit and all the noises.
>
> I really never thought a hospital was a motel, but I know I never want to be a patient again unless absolutely necessary.
>
> I walked on my first day post-operatively and went home on the 4th day where it is quiet.
>
> Is there someone I can contact or is there a committee to improve or lessen noises in hospitals?"

Recently an acquaintance of mine returned from a trip to learn that his 10-year-old daughter had been rather precipitously hospitalized for what turned out to be a trivial matter. He hastened to visit his anxious child and found her in a bed which, separated by glass partition, faced a nursery with several severe hydrocephalics.

Another paitent, well into her seventies, was hospitalized for thrombophlebitis. She was given a constant I.V. drip of heparin and confined to bed. She was unable to reach her bedpan on one occasion and was unable to attract any help. Several of the ward helpers were surly and unnecessarily rough. The thrombophlebitis improved without event but that lady will not return to that hospital.

In one metropolitan center, patients are transferred from the community hospitals to the city hospital. Over a three-month period, the city hospital has kept a record of the 590 such transfers; 25% of these patients were classified by the receiving hospital as being unfit for transfer. These patients were transferred in shock, in coma, in pulmonary edema, in all manner of jeopardy and almost invariably without records. Each of these hospitals is fully accredited and recognized for excellent medical care. What about patient care?

A British study, financed by the Nuffield Provincial Hospitals Trust, discovered that hospitals having difficulty in keeping nursing staffs would have difficulty in treating patients. A ward permanently short of staff, or with a chronic high rate of turnover, could not provide treatment for patients to the level of that provided in a hospital with a stable staff. Also, the patients require more time for recovery. An examination of the length of stay of five

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†*Presented at the 38th Annual Convention of the Kentucky Hospital Association, April 26, 1967, Louisville.*

**Director, Department of Hospitals and Medical Facilities, American Medical Association*

main classes of patients in the five hospitals showed that those hospitals with the stable staffs had short periods of patient stay, and vice versa. The differences between those hospitals in average length of patient stay, irrespective of diagnostic group, were to the order of 50%. The question was raised: If certain surgical patients in one hospital remain 50% longer than the corresponding surgical patients in another, are they also prepared more slowly for their operations? The study reported that hospitals slow in preparing patients for surgery were also slow in discharging them and vice versa.

The British study also noted that: The medical patients are more dependent upon hospital factors than the surgical, and this, with other evidence, supports the view that the communication system significantly determines the quality of the hospital in speeding or delaying the discharge of its patients.

Further, it was noted that hospitals are institutions cradled in anxiety. Patients are anxious not only about their own health, but about their families. Not a few principal officers of hospitals are uneasy about their relations with the hospital management committees. It is a striking fact that on most hospital wards, the only persons who seem permanently secure are the cleaners; middle class patients rarely fail to comment about the cheerfulness and equanimity of the domestics, and frequently turn to them for information or help rather than to the nursing staff. This is not a matter of temperament; it is a freedom from insecurity, since the cleaner knows precisely what she has to do and, in an atmosphere of tension and anxiety, radiates an effulgent calm.

Quality of patient care has many facets. The lack of quality of care may be a function of noise, of potential or real psychic trauma, of indignity and rudeness, of poor medical judgment, of manpower shortages and of many other factors as well. Some of the patients' complaints may seem trivial, but a complaint is an erosion of quality. Further, a patient-centered measure of quality of care has to take into account the end result. Clearly, patient care would not be adjudged excellent if, in a warm and friendly environment, diabetics were permitted to slide into acidosis. There is no single measure of the quality of patient care. There is, morever, no one single organizational unit of medicine responsible for insuring it.

The various levels of organized medicine have various connections with accreditation. The composition of the Joint Commission gives the multiple voices of organized medicine an opportunity for expression. As noted, the Commission has three members from the American College of Physicians, three from the American College of Surgeons, and seven from the American Medical Association. Included on the AMA membership are general practitioners, a psychiatrist, an obstetrician, a pathologist and an internist. Rounding out the membership on the Commission are seven members from the American Hospital Association.

The standards can and do flow from considerations at local levels. Each year the AMA House of Delegates has presented from various state societies resolutions in regards to standards for accreditation. In some instances efforts to relax standards are presented; in others, efforts to make higher or more stringent standards are presented. Each group of commissioners has the opportunity to introduce new standards *de novo*. A few brief examples might be pertinent. Two examples may be cited from the June '66 meeting of the House of Delegates: the Resolves of these read:

Resolution No. 6

Resolved, That the American Medical Association recommend that the Joint Commission on Accreditation of Hospitals delete the time limit in question, and substitute "The patient shall be seen within a reasonable length of time relating to the disease or injury that exists.

Resolution No. 44

Resolved, That the House of Delegates of the American Medical Association direct its Board of Trustees to petition the Joint Commission on Accreditation of Hospitals to adopt a policy on staff appointments to provide that, before terminating or failing to renew an appointment, the physician concerned shall have a hearing before the agency recommending termination or non-renewal of such appointment.

The AMA Commissioners presented the matter to the Joint Commission as the House directed. As a result, you will recall the 15-minute constraint was amended to read "within a reasonable time." Resolution 44 is being considered. Clearly, the Joint Commission is responsive to its membership as represented by commissioners.

National bodies have only broad policy-making powers. This is true whether one is speaking of government or of professional accrediting bodies. A requirement that a patient have a physician within 15 minutes after entering an emergency room makes no practical sense in rural, physician-short America. Further, national accreditation cannot practically determine the quality of patient care in hospitals. Who is to perceive the juxtaposition of monsters and healthy children, the divorce between the bedpan and the bedfast bottom, the medical and hospital neglect in interhospital transfers, the waste and inefficiencies of poor hospital administrative practices?

From a medical point of view, the California Medical Association has accepted this challenge. Their program is a notable example of organized medicine's efforts to fulfill its responsibilities. Let me quote from the Proceedings, Blue Cross of Southern California, "A Time for Decision: to Act or React?" published in 1963:

> The California Medical Association has appointed a statewide survey committee which is available to assist the local committees with their first survey. The local committee may consist of a representative appointed by each of the hospital medical staffs within the community. The committee's activity is the continual observation of all of the hospitals within their community. The initial survey team that goes into any given hospital has re-

presentation from the state committee as well as the local committee. A physician assigned to the local committee will not be on the team that surveys the hospital where he does his major work. On invitation, a careful survey is made of the medical staff review committee's activity within the hospital. When they are found to be functioning properly, the hospital medical staff is given a certificate of approval by the California Medical Association. If they are not, recommendations are made which point out their weaknesses and suggestions are made for improvement. Subsequent surveys of the hospital are made by the local committees, and if found to be complying with the standards, a certificate is issued.

In reviewing the factors affecting voluntary control of patient care, it seems that programs of such dimensions are called for, if the principle of "self-government" is to be retained.

In defending the need for such supplementation of the Joint Commission, an officer of the state association stated: "A one- or two-day visit by a surveyor from Chicago has its place, but is not adequate to do the type of continual day-to-day and week-to-week review that is so essential in discharging our activities.

"We have said that only a physician is competent to review the work of physicians. The public expects the law authorizes (us) to establish and maintain necessary means to judge competence and assure quality care on a voluntary, self-educational and disciplinary basis. If we do not exercise this privilege, it will be forfeited and passed to the state to be administered on a compulsory basis with standards established and enforced by it . . . The time has long since gone for merely talking a good game—we must demonstrate that we mean business . . ."

Thus, in organized medicine there are now defined two roles for accreditation: The Joint Commission at the national level, and a cooperative state and county society at the local level. Not many states have followed the California model. For most states and, therefore, most patients, the quality of patient care suffers from the long gap between Chicago and the hospital. This brings me to the role of the organized medical staff is connection with accreditation and its effect on the quality of patient care.

The organized medical staff is, for medicine, the administrative unit. Policy set at national and state levels must be implemented by the hospitals. Most hospitals are like Gaul—divided into three parts: The medical, the nursing, the administrative. Each of these operate too often in a discoordinated fashion so that rooms are assigned to inform basically healthy children of monsters, so that physicians reply only that the distance between the bottom and the bedpan is a nursing problem, so that employee turnover is the problem of administration, so that inappropriate transfers are the problem of the medical staff. Quality patient care can only be achieved through a concert of these forces. Most hospitals are now structured to defeat quality patient care.

Responsibilities for components of care are compartmentalized with insufficient means for horizontal communication. Too often utilization review is carried out as solely a medical function. Evidence suggests that extended stays may result from nursing and administrative practices as well as medical. Nursing care plans are conceived and implemented without the involvement of physicians or administrators. In spite of the effort and concern of the administrator, the nurse and the physician for quality care, an optimal package has not been developed.

The Evanston hospital has considered the organizational problem. Each ward has an administrative assistant, a nurse in charge and a physician in charge. The problems of communication relating to patient care are solved at the bedside. Thus, all components are involved in implementing the standards for accreditation.

Bulletin 40 of the Joint Commission amended medical staff functions as follows:

Administrative Functions

The effective discharge of the responsibilities of the medical staff will depend in great part on the clear assignment and full acceptance of each responsibility by the entire staff, its officers, individual members, committees or other mechanisms formed to deal with the specific tasks identified in Section II A. above. The form and complexity of organization of the medical staff needed to discharge these responsibilities effectively is a determination which must be made by the medical staff of each individual hospital. They will vary substantially depending upon the size, composition and disposition of each staff. While committee establishment will be a common device, other methods will be acceptable to the Joint Commission *provided effectiveness can be demonstrated by the documentation of activities.*

Provision for keeping the entire medical staff informed concerning the accreditation program, the current accreditation status of the hospital and the factors influencing that status;

Surveillance of the quality of patient care provided in the hospital by the promotion and maintenance of the following elements:

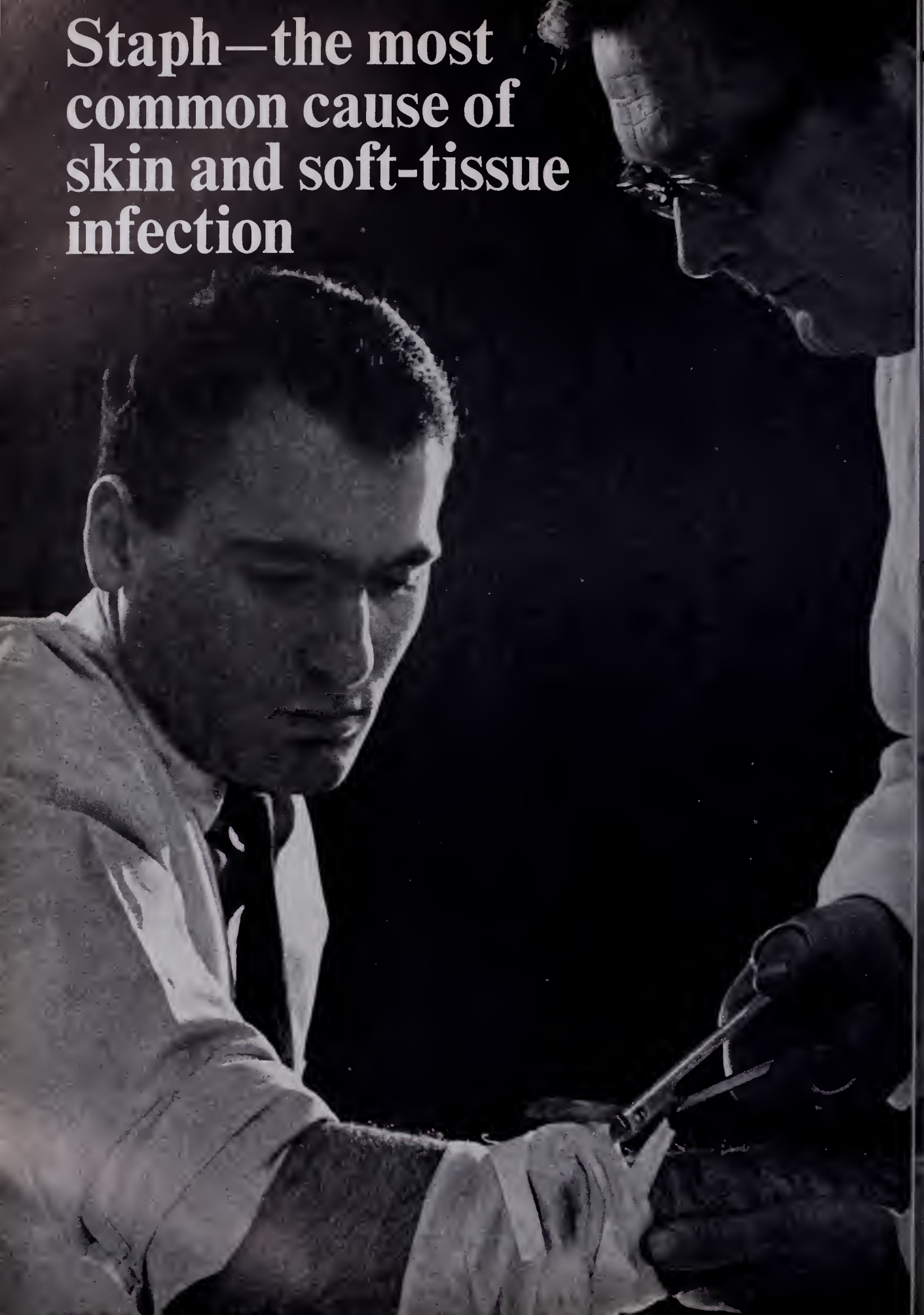
i) Currently maintained medical records describing the condition and progress of the patient, the therapy provided, the results thereof, and the placement of responsibility for all actions taken in sufficient completeness as to assure transferable comprehension of the case at any time;
(Commonly Records Committee Function)

ii) Review and clinical evaluation of the quality of medical care provided to all categories of patients on the basis of the documented evidence;
(Commonly Medical Records, Tissue and Medical Audit Committee Function)

iii) Review of hospital admissions with respect to need for admission, length of stay, discharge practices and evaluation of the services ordered and provided;

(Continued on Page 913)

Staph—the most common cause of skin and soft-tissue infection



..reliably controlled with specific therapy



A suitable dosage form for every staph situation

Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Whenever you suspect staph PROSTAPHLIN®

SODIUM OXACILLIN



Photo professionally posed

Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —PEN·VEE® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

ORAL **PEN·VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

EDITORIALS

Y'All Come

THOUGH the hour is late, and the event is almost upon us, we of The Journal Editorial Staff wish even now to remind our faithful Readers of what has come to be indeed a many-splendored thing—the annual meeting of the KMA. It will be held (watch that d, printer) in Louisville September 26 through September 28.

In any attempt to enumerate the wonders of this 116th convocation, mere words fail miserably. Let your imagination, instead, explore the delights of the all-too-infrequent reunions (male and female, formal and informal), the thrill of the latest in scientific and technical exhibits, the stimulation of Kentucky (medical) politicking, as practiced in the Delegates' Meetings—and elsewhere. Consider well the opportunity to learn from a fine Scientific Session—highlighted by a Transatlantic CPC on GI Bleeding, and by nationally known experts in many fields. Take note of the Specialty Group meetings. Remember the KEMPAC Forum Monday night with Louie Nunn and Henry Ward. Speculate about the Golf Tourney Monday at a fine new country club.

Ask yourself (and your wife) if three or four days in Louisville wouldn't be a welcome respite from the daily routine. Wouldn't it? (Aside to Louisivillians—remember to block out KMA meeting time—you know what will happen to your good intentions if you don't.)

OK now—generate up coverage for the ole practice (yes you can!) and come! The more of us there are the more we can learn from each other. See you there.

WALTER I. HUME, JR., M.D.

Sex

THE ROLE of the physician changes from time to time and is dependent upon many variables. We are in a most unique position, for although our job is to relieve suffering and stave off death, we can at best only temporize, since all of our patients are going to die someday of something. We are one of the few callings who are in business to do ourselves out of business. Our greatest accomplishments have really been in the field of prevention, of keeping a disease, a disability, or a dysfunction, from occurring in the first place. It seems odd, then, that we, the preventers, the healers, would do so little about a preventable phenomenon which kills about 60,000 men, women, and children a year, and injures about 4.5 million.

What really is our responsibility and what are we doing about it? It would appear that our responsibility is great as we see the horrible results and know that practically all of these occurrences are preventable. Unfortunately, we do not seem to be doing too much about seeing to it that they do not take place.

Modern Medicine published a series of articles this spring about "The Physicians' Role in Highway Safety" and the Travelers Insurance companies have just sent out a booklet called "Was It Sudden?" They both point out ways we can help to reduce the accident rate with its concomitant pain and anguish. They suggest that simply to blame the car, the driver, alcohol, poor roads, or any one single cause is far from a scientific approach. The causes of accidents are many and work in a "system," or chain reaction to cause a tragic or happy ending to a driving experience. There is a car in more or less good condition, there is you, tired, awake, worried or relaxed, on a road well-lighted or dark, wet or dry, and then add or take away any one of another thousand or

more factors, and you may have some leads as to the causes of accidents.

What then can you and I do about applying good scientific methods to accident prevention? Some of the suggestions we can follow to help prevent accidents ourselves include always, and in all ways, driving defensively, maintaining our cars in the best possible shape, and insisting on owning all optional safety devices, including the proper tires at the proper inflation for your car. Limit your driving when tired, emotionally upset or drinking. Adjust your driving and speed to current conditions of highway, weather, traffic or other conditions. Don't rush, keep your temper, and personally, in your own community, support better law enforcement, highway improvement, driver education in the schools and improved driver licensing. Be firm about your patient's medical disability which should keep him or her from driving a car.

Now how can we help prevent injury in the case of the so-called "second collision," that is, the passenger colliding with the inside of the car? First and foremost, *use* the seat belt and shoulder harness. Insist upon buying that car and driving that car with the greatest number of safety features, such as padded dash, collapsible steering wheel and head supports, and always remember, the higher the speed, the greater the severity of the accident.

There are misconceptions in the minds of some people which we must help put aright. For example, some have suggested that a seat belt would prove fatal in case of fire or submerging. The facts are that the chances of survival are greatly increased with the use of the seat belt as the passenger has been protected from the second collision and is, therefore, much more likely to be conscious and able to escape. In every discussion of safety, there is usually one person who knows of someone who was thrown out of a car and suffered only minimal injuries. For every one of those we can show you 10 whose lives were saved by being belted in. And so on and on with feeble excuses not to face the obvious fact that you and your family can be killed, or maimed, in your own car today. If you carry insurance on your car for fear it might be damaged, take out some safety insurance with yourself, for fear you and yours might be damaged. There is a shortage of doctors. Please don't be afraid to be afraid.

Oh, yes, if you have wondered why this editorial was entitled "Sex," be honest, now—would you have read it at all if it had been called "Automotive Safety?"

William K. Keller, M.D.
Chairman, KMA Committee
on Highway Safety

Something Special

THE Southern Medical Association will meet at the Hotel Fontainebleau in Miami Beach November 13-16, 1967. This should appeal to many of the 800 SMA members in Kentucky and we hope to have an even better than usual representation this year. Of the 17 southern states comprising the Association, Kentucky has always maintained a position of importance. We must continue so.

The Southern has long since outgrown Louisville as a meeting place. Through our Chamber of Commerce an invitation was extended for 1970 or 1971, but after careful consideration of facilities available, all concerned deemed our accomodations inadequate for so large a convention. So we must for the present be content to travel to the larger centers in the South for our annual conclave. This is not all bad—it at least gives us an excuse to enjoy a visit to some of our neighboring states.

Miami Beach affords the best Florida has to offer. To have the convention activities under one roof is a distinct advantage, and there is opportunity for recreation of whatever form you may choose. The scientific program is always good, and this year's fare promises to be up to the usual high standard. There will be something special for everyone.

Don't forget to bring your wife.

Sam A. Overstreet, M.D.

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

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QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Informotion: Composition: Each white, beveled, compressed tablet cantains: Quinine Sulfate 260 mg. and Aminaphylline 195 mg. **Controindication:** QUINAMM is cantraindicated in pregnancy because af its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in same instances, and quinine may produce symptoms af cinchanism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances accur. **Dosoge:** One tablet upan retiring. Where necessary, dosage may be increased ta one tablet fallowing the evening meal and ane tablet upon retiring. **Supplied:** Battles af 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiolagy, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

even in ulcerative colitis...

characterized by:
—diarrhea, cramps, tenesmus
—bloody, mucoid, purulent stools



LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

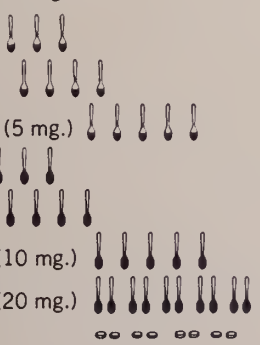
- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.



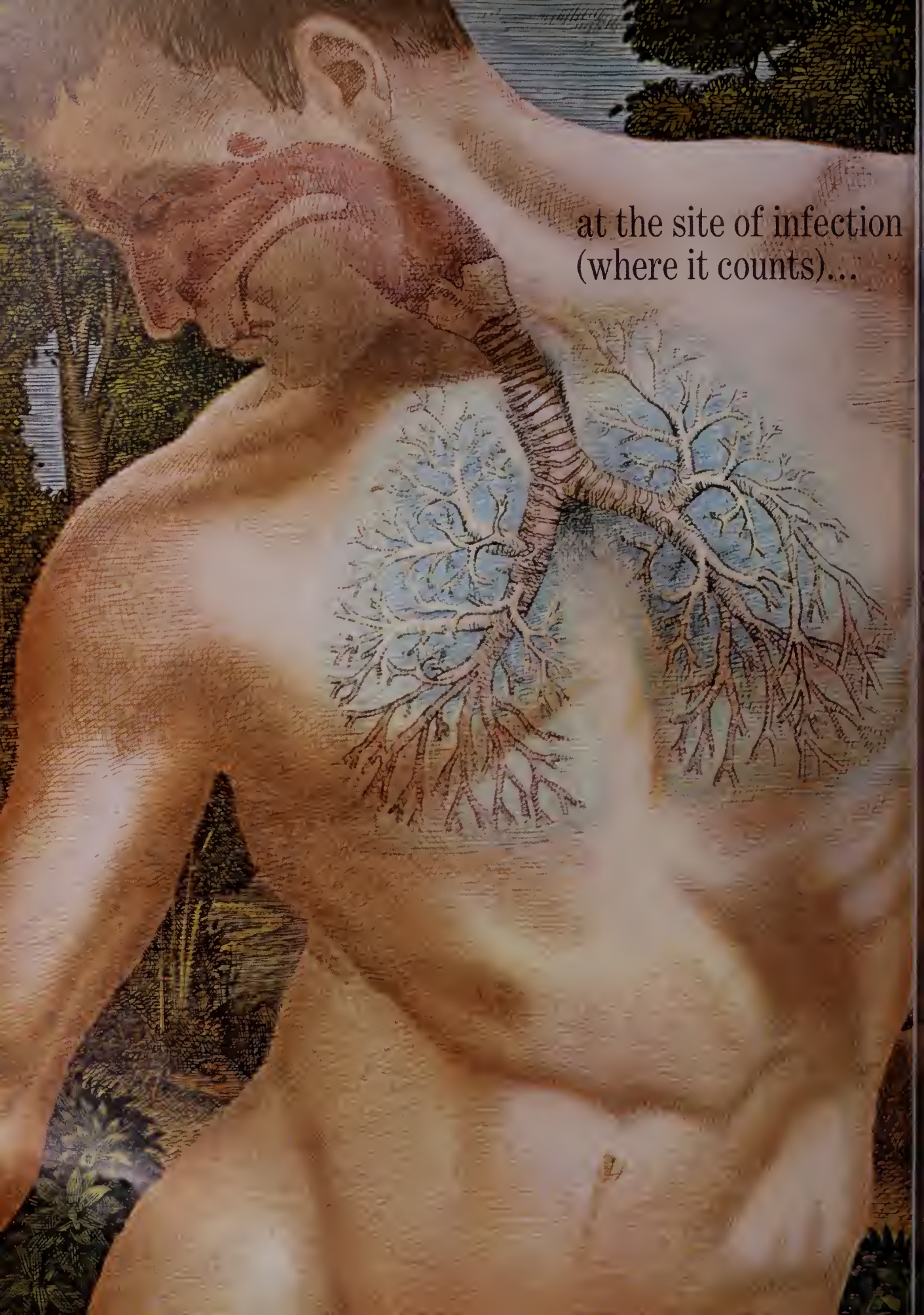
*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeai be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, anc mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses c medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six months patients with rheumatic fever have taken prophylactic do 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had epi of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mont rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who receivec icillin. There were no cases of jaundice in either group. Elev of SGPT and serum alkaline phosphatase levels during the c of treatment was observed in one patient treated with Il and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the peni group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus i tions. Results of liver function tests in these patients comparable to those in a similar control group who had rec penicillin.

Gastro-intestinal disturbances not associated with hepat fects are observed in a small proportion of individuals as a r of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hours children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual d of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythror therapy should be considered.

In the treatment of syphilis, the recommended total dos 20 to 30 Gm. given in divided doses for a period of ten to fi days. Close follow-up of the patient is necessary since ery mycin drugs have not had adequate evaluation in all stag syphilis. Examinations of spinal fluid are recommended as of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four day recommended. In the treatment of gonorrhea, patients w suspected lesion of syphilis should have a dark-field examin before receiving antibiotics, and monthly serologic tests s be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pack

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pack

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to b in bottles of 50. [03

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69,
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398,
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

ORGANIZATION SECTION

Chicago Bears Surgeon To Give First Scientific Presentation

Theodore A. Fox, M.D., Chicago, orthopaedic surgeon for the Chicago Bears Football Club, will be the first speaker on the scientific program of the 1967 KMA Annual Meeting September 26. Doctor Fox will discuss "Internal Derangement of the Knee" as the subject applies to football players.



Doctor Fox

The guest of the Kentucky Orthopaedic Society, Doctor Fox is an associate professor of orthopaedic surgery at R & E Hospitals, University of Illinois College of Medicine. He is chairman of the Subcommittee on Athletic Injuries of the Chicago Committee on Trauma, American College of Surgeons.

Another topic of interest to be presented during the first scientific session of the meeting is "Aerospace Medicine: A New Working Environment for Man," by Walter W. Kemmerer, M.D., Houston, Texas, Chief of Biomedical Specialties Branch of NASA.

Doctor Kemmerer, guest of the Kentucky Industrial Medical Association, joined NASA in 1964. As chief of the Biomedical Specialties Branch, he is responsible for microbiology experiments in manned space flight operations. He graduated from Baylor University College of Medicine in 1959 and received his master of public health degree from the School of Public Health, Harvard University, in 1964.



Doctor Kemmerer

There will be a total of four general scientific sessions during the Annual Meeting, including a Transatlantic CPC on Wednesday afternoon, September 27. The topic for that session will be "Gastrointestinal Hemorrhage" which will be discussed by four KMA panel members and three panel members in London, England.

Another highlight of the meeting will be the President's Luncheon at 11:50 a.m. Wednesday, September 27. Nicholas P. Dallis, M.D., Scottsdale, Arizona, author of the nationally famous "Rex Morgan, M.D.," comic strip, will be the guest speaker.

Other events planned during the annual session include meetings of 16 specialty groups, scientific and technical exhibits, the KMGA golf tournament, U of L alumni reunions, an orientation course for new members, the annual KEMPAC Seminar, and two meetings of the KMA House of Delegates. (See August issue of The Journal for complete details.)

CMA President-Elect To Appear On KEMPAC Seminar Program

Malcolm C. Todd, M.D., Long Beach, president-elect of the California Medical Association and an AMPAC Board member, will be among the featured speakers at the annual KEMPAC Seminar, according to John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board. The event is scheduled for 6 p.m. Monday, September 25, in the Flag Room of the Kentucky Hotel.

Sharing the program with Doctor Todd will be Kentucky's two gubernatorial candidates, Democratic nominee Henry Ward and Republican nominee Louie B. Nunn. The candidates have been asked to speak on the role of the physician in political action.

Doctor Todd graduated from Northwestern University School of Medicine in 1938 and completed his internship and residency training in Chicago hospitals. He has served as a delegate and alternate delegate to the AMA and was a member of the CMA House of Delegates for 12 years. He is a fellow of the American College of Surgeons, International College of Surgeons, Industrial Medical Association and the American College of Gastroenterology.

In addition to his extensive participation in the activities of the profession, Doctor Todd is active in community affairs which include Kiwanis, Chamber of Commerce, Red Cross and Torch.

IMPORTANT

COUNTER CHECKS NO LONGER HONORED

You will be unable to use counter checks at the KMA Annual Meeting since banks ceased to honor them effective September 1. Please be sure to bring an adequate supply of checks imprinted with your account number from your bank if you anticipate writing checks during the meeting.

Scientific Exhibits Depict Recent Medical Progress

Fifteen scientific exhibits, featuring the most recent developments in medical research and techniques, will be presented this year at the KMA Annual Meeting, according to Thomas R. Marshall, M.D., chairman of the Committee on Scientific Exhibits.

Located in the Convention Center between the Technical Exhibit Hall and the Scientific Assembly Hall, the exhibits are conveniently arranged for easy access.

The exhibitor with the outstanding scientific exhibit at the meeting will be presented with a plaque by KMA and in addition will receive a check in the amount of $200 and a certificate from Mead Johnson Laboratories as winner of the Aesculapius Award. Each exhibitor will also receive a certificate from KMA.

A list of exhibitors follows:

X-Ray Viewbow Quiz
Thomas R. Marshall, M.D.

The Urinary Tract in Anomalies of the Sacral Spine
Max E. Blue, Jr., M.D.
Kenneth N. Walton, M.D.
University of Kentucky Medical Center

Physiological Effects of Pulmonary Histoplasmosis
William H. Anderson, M.D.
University of Louisville School of Medicine

Fertility Control with the I. U. D.
Ralph R. Robinson, M.D.
Robinson Medical Clinic

X-Ray Protection for Patient and Operation
Kentucky State Department of Health

Peritoneal Dialysis in Private Practice
William E. Anderson, M.D.

Photographs of the Eye
William Edwards, M.D.
Robert Kaiser, M.D.
Walter R. Morris, M.D.
Roger Salot, M.D.

The Jaundiced Human
Malcolm L. Barnes, M.D.

Medical Quiz
F. Albert Olash. M.D.

Chromosomes and the Funny-Looking Kid Syndrome
Leonard E. Reisman, M.D.
University of Louisville School of Medicine

Physiological Effects of Pneumonia
William H. Anderson, M.D.
University of Louisville School of Medicine

Cervical Cancer Screening Program
C. Hernandez, M.D.
Kentucky State Department of Health

Vaccination Program—Ky. Department of Health
Kentucky State Department of Health

Carcinoma of the Cervix in Jefferson County
William H. Christopherson, M.D.
University of Louisville School of Medicine

The Management and Treatment of Lip Pathology
Robert C. Kratz, M.D.
Alvin C. Poweleit, M.D.

Kentucky Chapter, ACP, Plans Scientific Meeting Sept. 16

The Kentucky Chapter of the American College of Physicians will have a one-day meeting Saturday, September 16, at Stouffer's Inn, Louisville, which will include two scientific sessions, a luncheon and banquet, according to Ellis A. Fuller, M.D., Louisville, chairman of the program committee.

The featured speaker at the meeting will be Thomas M. Durant, M.D., Philadelphia, regent and past president of the American College of Physicians. Doctor Durant will discuss "Angina Pectoris, Then and Now," during the scientific program and will be the guest speaker for the banquet.

Other speakers on the program will be Billy F. Andrews, M.D., Franklin B. Moosnick, M.D., Capt. Donald M. Ginsberg (MC), U.S.A., Paul Mandelstam, M.D., John D. Lovett, M.D., William Gaventa, M.D., Franklin G. Hoffman, M.D., Leonard B. Berman, M.D., David H. Johnston, M.D., Bruce Williams, M.D., William H. Anderson, M.D., Thomas Stephenson, M.D., and S. Spafford Ackerly, M.D. George W. Pedigo, M.D., Louisville, is general chairman for the meeting.

Infections Control Conference Scheduled October 11-12

A conference on "Infections Control in Hospitals" will take place October 11 and 12 at the University of Louisville's Bigelow Hall, according to G. Dudley Nelson, M.D., one of the program chairmen. The purpose of the conference is to define the problem of hospital associated infections and the responsibilities and liabilities incurred by them.

Nationally experienced personnel from the U.S. Public Health Service's Communicable Disease Center and Division of Hospital and Medical Facilities will appear on the program, Doctor Nelson said.

The conference is sponsored by the University of Louisville in cooperation with the Kentucky Medical, Hospital and Nurses Associations, the University of Kentucky and the State Health Department.

Doctor Nelson urges all physicians, hospital administrators and nurses throughout the state to attend the conference. Programs, registration forms and other information will be mailed at a later date.

Many Medical Groups To Meet During KMA Annual Session

Some of the miscellaneous meetings planned in conjunction with the 1967 KMA Annual Meeting will be of interest to you. The date, hour and location of all meetings known at press time are listed below.

Sunday, September 24

12:30 p.m. KMA Board of Trustees Luncheon Meeting, Parlor A, Kentucky Hotel
5:00 p.m. Social Hour, U. of K. Medical School, Parlors B and C, Kentucky Hotel
6:30 p.m. Board of Directors, Blue Shield, Dinner, Ship Room, Kentucky Hotel

Monday, September 25

8:00 a.m. Awards Committee Breakfast, Room 201, Kentucky Hotel
8:30 a.m. Orientation Program, New KMA Members, Mirror Room, Kentucky Hotel
9:00 a.m. KMA House of Delegates Meeting, Terrace Room, Kentucky Hotel
10:00 a.m. Tee-Off Time, KMGA Golf Tournament, Hurstbourne Country Club, Tee-Off Deadline 2:00 p.m.
12:30 p.m. Reference Committee Chairmen Luncheon, Room 317, Kentucky Hotel
2:00 p.m. Seven Reference Committee Meetings, Parlors A, B, C and D, Rooms 203, 204, and 205, Kentucky Hotel
6:00 p.m. KEMPAC Reception, Banquet and Seminar, Flag Room, Kentucky Hotel

Tuesday, September 26

11:50 a.m. Movie "The One Who Heals," General Assembly Hall, Sponsored by KMA Medicine and Religion Committee
12:00 Noon Kentucky Industrial Medical Association, Luncheon, Room 317, Kentucky Hotel
1:00 p.m. Kentucky Diabetes Association, Meeting Parlor B, Kentucky Hotel
5:00 p.m. Kentucky Society of Anesthesiologists, Social Hour, Parlor A, Kentucky Hotel
6:00 p.m. Kentucky Chapter, American Academy of Pediatrics, Social Hour and Dinner, Executive Inn
6:00 p.m. Kentucky Urological Association, Social Hour and Dinner, Oak Room, Sheraton Hotel
6:00 p.m. Kentucky Diabetes Association, Social Hour, Room 1510, Kentucky Hotel
6:30 p.m. Kentucky Chapter, American College of Chest Physicians, Social Hour and Dinner, Ship Room, Kentucky Hotel
6:30 p.m. Kentucky Dermatological Society, Dinner, Parlor C, Kentucky Hotel
7:00 p.m. Kentucky Diabetes Association, Dinner, Parlor B, Kentucky Hotel

Wednesday, September 27

7:00 a.m. Committee on Medicine and Religion, Breakfast, Parlor A, Kentucky Hotel
8:00 a.m. Transatlantic CPC Panel on "Gastrointestinal Hemorrhage" Breakfast, Room 201, Kentucky Hotel
9:00 a.m. State Board of Health Meeting, Room 317, Kentucky Hotel
11:50 a.m. President's Luncheon, Flag Room, Kentucky Hotel
5:00 p.m. Board of Trustees Meeting, Parlor B, Kentucky Hotel
6:00 p.m. Board of Trustees Dinner, Parlor A, Kentucky Hotel
6:00 p.m. House of Delegates Subscription Dinner, Terrace Room, Kentucky Hotel
6:30 p.m. Kentucky EEN&T Society, Social Hour and Dinner, Executive Inn
7:00 p.m. House of Delegates Meeting, Terrace Room, Kentucky Hotel

Thursday, September 28

7:00 a.m. MEA Liaison Committee Breakfast, Room 203, Kentucky Hotel
7:15 a.m. KMA Maternal Mortality Study Committee, Breakfast Meeting, Room 204, Kentucky Hotel
7:45 a.m. KMA Legislative Council and KEMPAC, Joint Breakfast Meeting, Parlor A, Kentucky Hotel
12:00 Noon KMA Board of Trustees Luncheon, Parlor A, Kentucky Hotel
12:00 Noon Kentucky Society of Pathologists, Luncheon, Parlor C, Kentucky Hotel
12:00 Noon Kentucky Chapter, American College of Surgeons, Luncheon, The Old House
12:15 p.m. Kentucky EEN&T Society, President's Luncheon, Ship Room, Kentucky Hotel
5:00 p.m. Kentucky Psychiatric Association, Dutch Treat Bar and Buffet Dinner, Mirror Room, Kentucky Hotel
6:00 p.m. Kentucky Chapter, American College of Radiology, Social Hour and Dinner, Sheratc . Hotel

AMA To Hold Clinical Convention In Houston, November 26-29

The American Medical Association will hold a Clinical Convention November 26-29 at Astro Hall in Houston, Texas. Special features of the four-day convention include scientific sessions, postgraduate courses, breakfast roundtable conferences, closed-circuit TV and scientific exhibits.

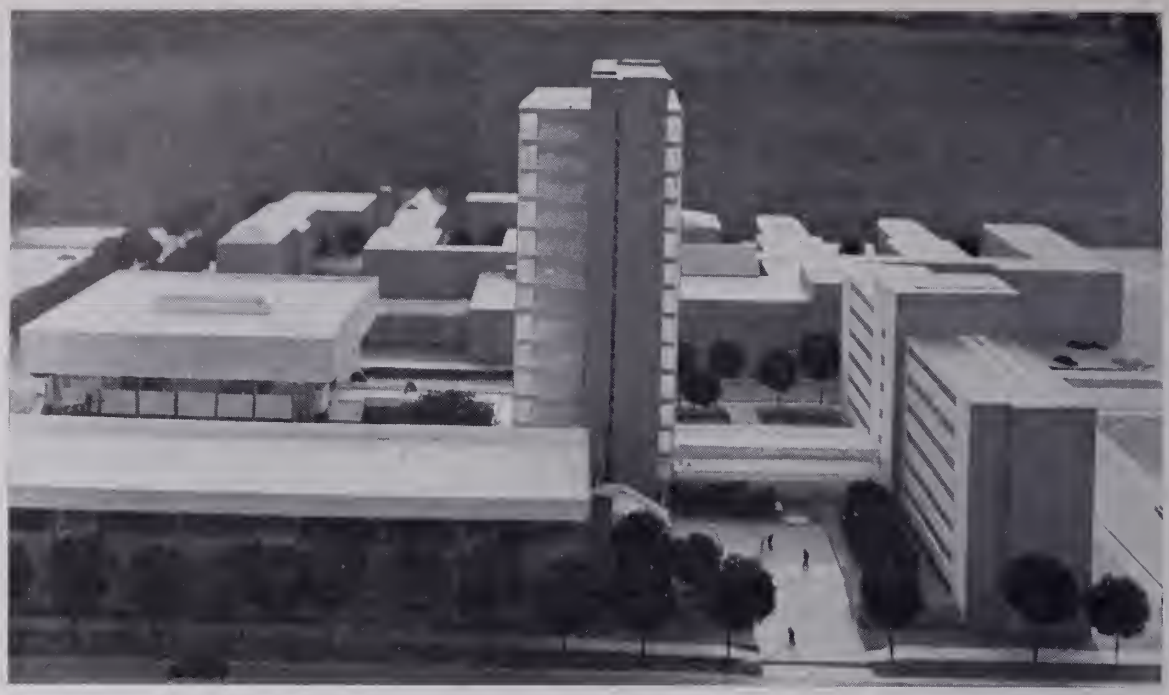
The scientific sessions will cover 18 major topics and will feature a "new cares" discussion of legal and social problems facing physicians today. Three one-half day sessions of postgraduate courses will cover Fluid and Electrolyte Balance, Oncology, Cardiovascular Disease, and Obstetrics and Gynecology.

The closed-circuit color television program will present live broadcasts of surgery and discussions from Houston's Hermann Hospital. Medical motion pictures will also be shown.

During the convention the AMA House of Delegates will meet at the Shamrock-Hilton Hotel. Also in conjunction with the convention, the Ninth National Conference on the Medical Aspects of Sports is planned for Sunday, November 26, at the Hotel Americana. AMA President Milford O. Rouse, M.D., invites all physicians to attend the convention.

Norton Fall Conf. To Be Dec. 14

The annual Norton Memorial Infirmary Fall Conference, a medical post-graduate program, is scheduled for December 14. Complete information will appear in a later issue of The Journal.



Proposed University of Louisville Medical-Dental Complex. View looking south.

Grant Enables U of L To Begin New Medical-Dental Complex

A $9.7 million federal grant will enable the University of Louisville to begin construction of a $24 million medical-dental complex next summer. The recently announced grant brings the total of federal funds for the project to $12.4 million. Other funds will come from city and state bond issues.

The proposed complex will replace the old medical and dental school buildings which are badly cramped and will permit a significant increase in enrollment. Completion is expected in September of 1969.

The new complex will be situated on both sides of Preston Street south of Walnut in the downtown medical center. The area is adjacent to General Hospital.

The new structures will include a medical library with a 400-seat auditorium and a 14-story faculty research tower.



Proposed Research Tower of University of Louisville Medical-Dental Complex as viewed from the Dental Instructional Building looking west. The Library is shown at left; the Medical Instructional Building is at the right.



fall 1967

DORSEY

Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air migh do this. A siege of smog in Denver, the "mile higl city," in December 1965 was accompanied by respi ratory infection that doubled normal absentee rate in schools, factories and city government.[10]

While air pollution is only one factor, it has becom important in the causes of most of the afflictions o the respiratory tract. This has been shown not onl by the Denver occurrence, but also by detailed study of respiratory illness in a small group of 313 me



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

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(Advertisement)



At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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(Advertisement)

Medical Assistants To Hold Workshop in Covington

A workshop designed to provide helpful information in completing Medicare and Medicaid forms will be held by the Kentucky State Association of Medical Assistants at 9 a.m., September 24, at the Statler-Hilton Motel, Covington. Participating in the discussion will be Donald Smith, Lexington, a representative from the Mutual Life Insurance Company, and Evan Ray of the State Department of Health.

The program will also feature Thomas J. Ferriell, Jr., M.D., Elizabethtown, whose topic will be "The Advantages of Medical Assistants Groups," and Robert G. Cooper, M.D., Louisville, who will discuss "Plastic and Reconstructive Surgery." Another guest speaker, Riley Lassiter, Louisville, will talk on "Medical Ethics."

All medical assistants throughout the state are urged to attend the workshop by Mrs. Virginia Applegate, president of KSMA. There will be a $5.00 registration fee.

Ky. Pharmacists Elect Mr. Hager At Annual Convention

Vernon B. Hager, Nicholasville, was named president-elect of the Kentucky Pharmaceutical Association at its annual convention July 26 in Paducah. Mr. Hager will take office in July, 1968. Under a new policy of the Association, the office of president-elect was created this year.



Mr. Hager



Mr. Schwartz

Ralph Joseph Schwartz, Florence, was installed as president of the Association at the convention. A 1946 graduate of the Cincinnait College of Pharmacy, he is president-elect of the Florence Lions Club, a member of the Advisory Board of the Boone County Council for Retarded Children, and a member of the National Association of Retail Druggists and the Northern Kentucky Pharmacists Association.

Mr. Hager graduated from the University of Kentucky College of Pharmacy in 1949. He was the recipient of the Bowl of Hygeia Award in Pharmacy in 1963 and is a past president of the Nicholasville Chamber of Commerce and the Rotary Club.

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OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.[1-5]

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.[6] (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.[7-9]

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.



1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321,.1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: ibid. 9. Nichols, M.: ibid.

Optimil, the first optimum-nutrition infant formula

from a world leader in nutritional research... Carnation®

DOCTOR—
You are "Special"
AT

GENERAL LEASING

Because doctors have the highest credit rating, take better care of their cars, and are our best customers we extend to you

★ **SPECIAL RATES**
★ **SPECIAL TERMS**

LEASING
ANY MAKE
OR MODEL
NEW '68 CAR

Leasing is often better than owning a car. You have no capital investment and certain tax advantages. But the main thing is you always have a dependable car at your command—a brand new car every two years, or oftener, if you wish. See us for particulars of our special plan for doctors.

LEASING
MEDICAL OR
SURGICAL
EQUIPMENT

Young doctors just beginning practice who need complete office furnishings and medical or surgical equipment will find our leasing plan is specially designed for them. Established doctors planning enlarged facilities and new equipment will also find our leasing plan economical and convenient. Call us for details.

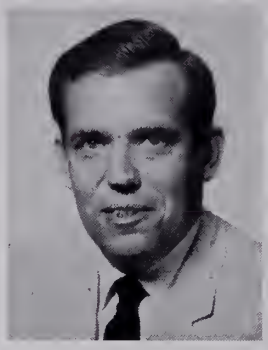
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UK Board of Trustees Appoints Dept. of Medicine Chairman

A Yale University professor, J. William Hollingsworth, M.D., has been named professor and chairman of the Department of Medicine at the University of Kentucky College of Medicine by the Board of Trustees. Doctor Hollingsworth will assume the chairmanship June 15, 1968.



Doctor Hollingsworth

The new chairman will succeed Edmund D. Pellegrino, M.D., who served five years as the department's first chairman before accepting directorship of the medical center at the State University of New York last September. Harris Isbell, M.D., acting chairman of the department, will continue in that capacity until Doctor Hollingsworth's arrival.

Doctor Hollingsworth graduated from Duke University School of Medicine in 1947 and has been an associate professor at the Yale University School of Medicine since 1961. While at Yale, he served as head of the arthritis section of the department of internal medicine and as director of the Yale Clinical Research Center.

Doctor Hollingsworth is presently spending a one-year sabbatical at Oxford, England, working in the areas of immunology, one of his major areas of interest which also include rheumatology and hematology. His wife is also a physician, and they have three daughters.

President's Late Father Honored

The late H. V. Pennington, M.D., father of KMA President Robert E. Pennington, M.D., London, was named outstanding citizen of the year by a proclamation authorized by the London City Council July 28. The late Doctor Pennington was chosen for his outstanding work as a surgeon and founder of the Pennington Hospital, now the Marymount Hospital.

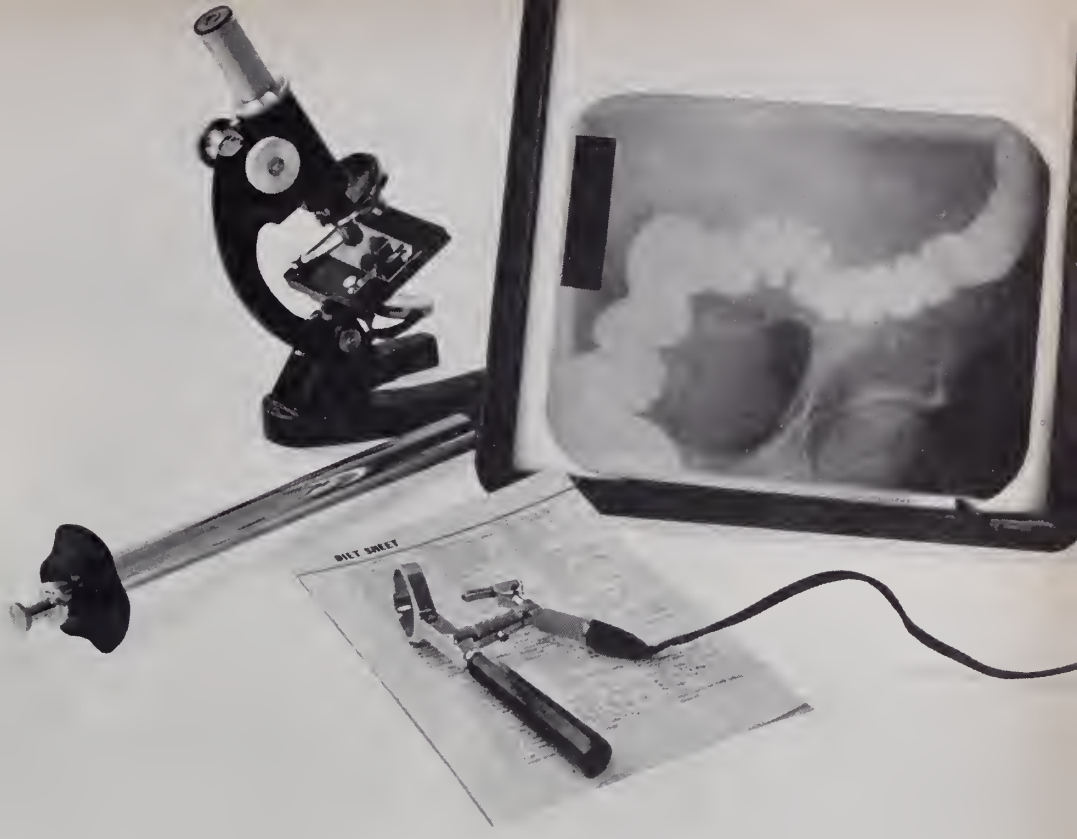
Ky. Blue Cross-Blue Shield Increases Benefits

Kentucky Blue Cross-Blue Shield have announced improved benefits in many subscribers' contracts effective August 1, 1967 at no additional cost. The improved benefits are as follows:

1. Children now covered from birth on all Blue Cross and Blue Shield contracts. (Standard Blue Cross and Blue Shield contracts formerly did not cover infants until 30 days after birth.)

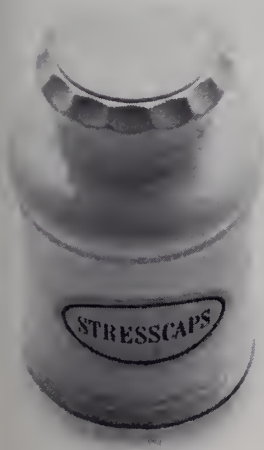
2. Mentally or physically retarded children now covered on parents' contracts. (Such benefits formerly ceased at age 19 and the retarded child had to be enrolled in a "single" membership.)

(*Continued on page 905*)



in digestive disorders:

B and C vitamins aid therapy. Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

692-6-1944

Lederle

Winthrop

announces

a breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent, injectable non-narcotic

For every physician who has ever prescribed morphine

Talwin is the new potent non-narcotic injectable analgesic which is indicated for relief of all types and degrees of pain in acute and chronic disorders. Talwin 30 mg. is usually as effective an analgesic as morphine 10 mg. or meperidine 75 to 100 mg., but needs no narcotics controls. The duration of action of Talwin may sometimes be less than that of morphine.

Talwin is relatively free from adverse effects o morphine, such as constipation, urinary retention or severe respiratory depression.

It has been used, in varying dosages, in ove 12,000 patients for relief of pain of medical dis orders, of active labor and postoperative pain also for preoperative or preanesthetic medication and as an adjunct to anesthesia.

A brochure incorporating analyzed information on Talwin is available. The completeness of the information will permit you to evaluate the role Talwin can play in your practice.

You can depend on Talwin to relieve pain:

WHATEVER the intensity of the pain
the cause of the pain
the site* of the pain
the duration of the pain
the chronicity of the pain
the age† of the patient

Talwin does not require a narcotics prescription

The World Health Organization Expert Committee o Dependence-Producing Drugs concluded that "...ther was no need at this time for narcotics control of penta zocine [Talwin] internationally or nationally." (*WH Tech. Rep. Ser.*, No. 343, 1966, p. 6.)

It is our sincere belief that the discovery of Talwin b Winthrop Laboratories will be of great value to you an your patients for whom you may have to prescribe potent analgesic.

*Talwin should not be used for patients with increased intracranial pressur head injury or pathologic brain conditions.

†Until sufficient experience is gained, it should not be administered to childr under 12 years of age.

Talwin—brand of pentazocine (as lactate)

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. *Patients in Labor.* A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: ***Ampuls of 1 ml.,*** **containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., **each 1 ml. containing Talwin (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

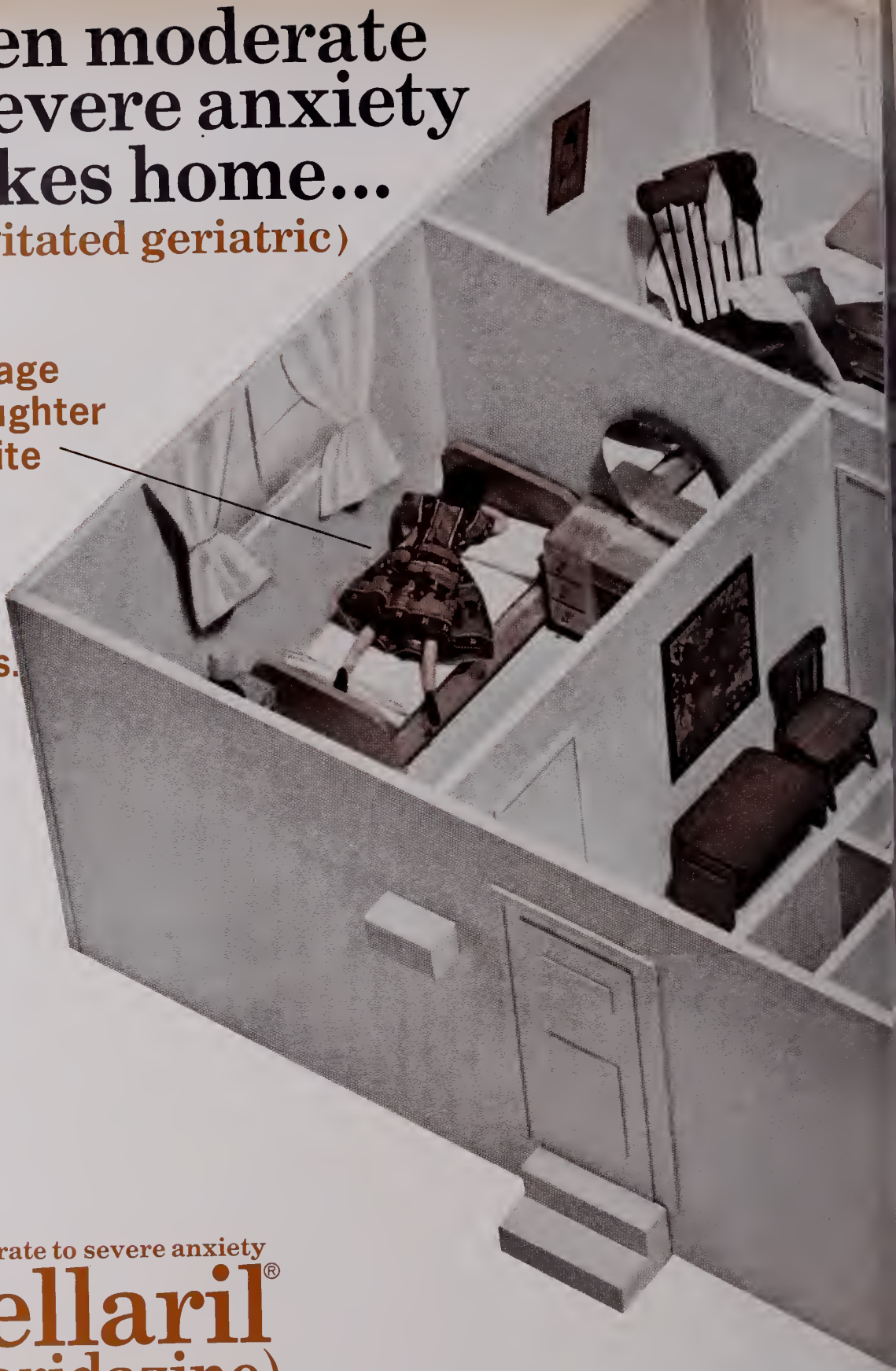
Winthrop Laboratories, New York, N.Y. 10016

(1150M)

When moderate to severe anxiety strikes home...

(the agitated geriatric)

His teen-age granddaughter won't invite friends home because of his outbursts.



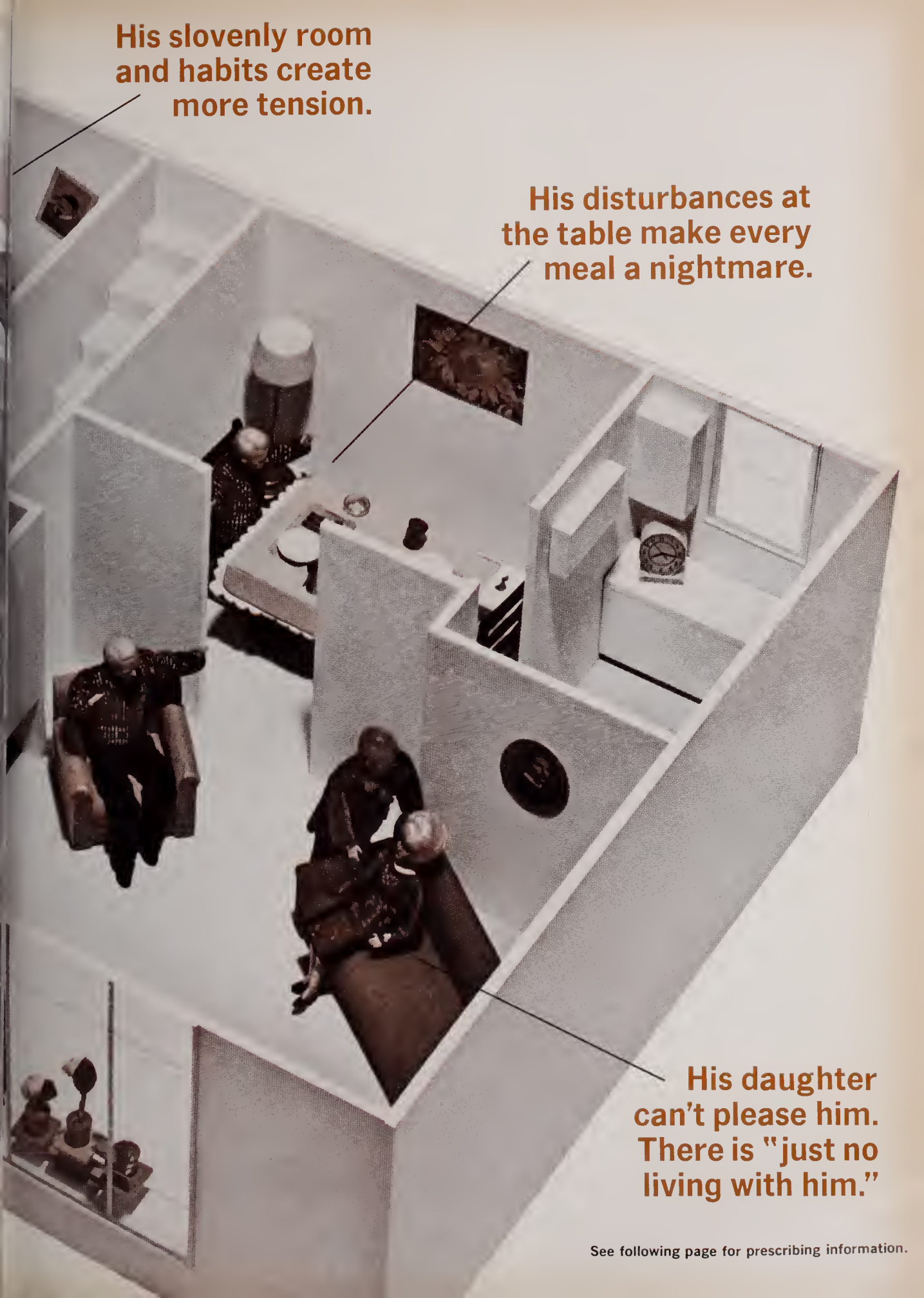
for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ



See following page for prescribing information.

When moderate to severe anxiety strikes home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate* to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

3. Expanded Blue Cross benefits for nervous and mental disorders. (Members now will receive benefits for 31 days in-hospital treatment, which is automatically renewed every time the patient is discharged and not readmitted to a hospital for a nervous and mental disorder for a period of 90 days.)

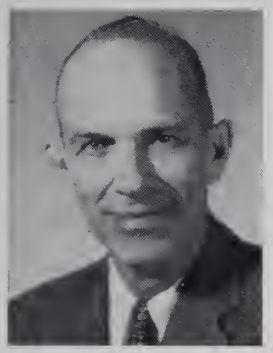
4. Blood processing service charges. (Blue Cross will now pay the service charge—where applicable—made by blood banks for the processing of whole blood when billed as a regular hospital service by member hospitals.)

Since many groups are merit rated it has been necessary to obtain their acceptance of these new benefits. All groups have been contacted and the majority have accepted the additional benefits.

Blue Cross-Blue Shield are also offering the Comprehensive Blue Cross Plan to all non group, direct pay and Farm Bureau Subscribers with room allowances of $15, $20 and $25. This Comprehensive Blue Cross Plan is being offered with Blue Shield Schedules "C" or "D".

Dr. Willard Chosen To Participate In Mission to South Vietnam

William R. Willard, M.D., vice-president of the University of Kentucky Medical Center, was one of six



Doctor Willard



Doctor Blasingame

doctors chosen to participate in a government-sponsored medical mission to South Vietnam in July. F. J. L. Blasingame, M.D., executive vice-president of the AMA, is in charge of the group.

The team of doctors is the first medical group to visit South Vietnam under the official auspices of the State Department, according to Senator Edward M. Kennedy (D-Mass.), who announced the mission in Boston July 25.

After briefing in Washington by Ellsworth Bunker, U.S. ambassador to South Vietnam, the doctors flew to that country where they will visit all the 150 provincial hospitals in an effort to improve care for Vietnamese civilian war casualties.

September Is Sight-Saving Month

The National Society for the Prevention of Blindness, Inc. is conducting its eighteenth annual Sight-Saving Month Campaign from September 1-30, according to Peyton Hoge, Sight-Saving Chairman of the Kentucky Society, an affiliate of the national organization. The theme of the campaign is "Early Detection for Early Correction."

NASA Names Dr. Musgrave Scientist-Astronaut

F. Story Musgrave, M.D., of the University of Kentucky Medical Center, was named one of 11 scientist-astronauts by the National Aeronautics and Space Administration August 4. Doctor Musgrave, who has been doing aerospace medical research in the department of physiology and biophysics, will become a space doctor for the astronaut program.



Doctor Musgrave

Doctor Musgrave has dreamed of becoming an astronaut since he was a fourth-year medical student at Columbia University. He has long been interested in flying, having logged 1,000 hours as a pilot. He has also made over 150 free-fall parachute jumps.

Although he will live in Houston during his three and one-half to four years of training to be an astronaut, Doctor Musgrave plans to continue his association with the University as a researcher.

Dr. Bell To Head Ed. Commission

Jesse B. Bell, M.D., Louisville, was elected chairman of the Kentucky Commission on Higher Education July 27. The 18-member commission makes recommendations to the U.S. Office of Education on allocations of federal funds to Kentucky colleges and universities. Doctor Bell, resident physician at Waverly Hills Sanatorium from 1935 to 1958, is a member of the University of Louisville Board of Overseers and the President's Advisory Council of Ursuline College.

College of Med. Receives Grants

Grants totaling $1,645,579 were recently awarded to the University of Kentucky College of Medicine according to published reports. R. W. Penman, M.D., in the Department of Medicine, received $199,376 from the National Institutes of Health for a study of "Chronic Lung Disease: Structure-Function Analysis."

Tom F. Whayne, M.D., acting dean of the College of Medicine, was awarded a grant of $161,493 from the Public Health Service, Division of Health Manpower, for a "Health Professions Education Improvement Program."

Blue Shield Announces Promotions

Promotions recently announced by Blue Cross-Blue Shield Plans include Dave Greenwell, Director of the Advertising Department, and Doug Sutherland, Director of the Professional Relations Department.



Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If an allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leucopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.

Wyeth® SERVICE TO MEDICINE

Equanil®
(meprobamate)
Wyeth

Professionally posed.

Drs. Auerbach, Kasey, Scheen Appointed by Governor

Governor Edward T. Breathitt recently reappointed S. Pearson Auerbach, M.D., Louisville, to the Commission for Handicapped Children and Arthur R. Kasey, Jr., M.D., Louisville, to the Advisory Council of Mental Health.

S. Randolph Scheen, M.D., Louisville, was appointed by the Governor as the KMA representative on the Advisory Council to the Kentucky Board of Nursing Education and Nurse Registration August 8. The appointment was made to fill the vacancy created by the death of Louis M. Foltz, M.D., Louisville.

The seven-member Council, created by the 1966 Kentucky General Assembly, serves in an advisory capacity of helping to establish and maintain standards of nursing and licensure regulations in the interest of public protection, according to KRS 314.121 (5).

Co. Societies May Get Requests For Aid on Health Topics

A number of national non-medical organizations have adopted program priorities for the next three years on matters relating to health, according to a recent announcement by the American Medical Association.

As a result of this program direction, county medical societies may receive requests for information, guidance and speakers on various health topics.

Some of the organizations involved in such health programs include the Young Woman's Christian Association, National Congress of Parents and Teachers, General Federation of Women's Clubs, National Extension Homemakers' Council and Pilot Club International.

Two Grants Awarded to U of L

The University of Louisville School of Medicine accepted a $208,377 grant from the U.S. Public Health Service July 19 which was awarded for the continuation of artificial kidney services at the chronic dialysis center.

The school's pulmonary disease laboratory received a $5,000 grant for equipment from the Kentucky Tuberculosis and Respiratory Disease Association's L. E. Smith Research and Medical Education Fund July 27.

Jaycees Elect Blue Shield Official

Doug Sutherland, director of the professional relations department at Blue Cross-Blue Shield Plans and immediate past-president of the Kentucky Jaycees, was elected vice-president of the U.S. Jaycees June 29 at the organization's annual meeting in Baltimore. Mr. Sutherland was also honored with the Clayton Frost Award given to him as one of the five outstanding state presidents of America.



Dulcolax®

isacodyl

DU-5255

Few drugs work as predictably as Dulcolax. You can expect that when your office patient takes Dulcolax at home, it will be as effective as you said it would be. Your patient will be gratified, too.

The reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

This reliable action provides prompt relief of constipation. It also makes Dulcolax particulary useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age a whole suppository is usually advisable. Side Effects: As with any laxative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

You may be prescribing Hygroton®, chlorthalidone

You usually prescribe one tablet daily, but every once in a while you like to cut the dosage. So instead of giving the 100 mg. tablet every other day or breaking it in half, why not prescribe the new half-strength tablet every day?

See next page for a brief precautionary statement.

but you don't know the half of it.

New Hygroton 50 mg.

For a clinical supply, please mail us this coupon with one of your prescription blanks.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

DEPT. 7

Broad scope diuretic

Hygroton
chlorthalidone

Hygroton is indicated in certain conditions where the newer nonthiazide diuretics are not recommended, e.g. hypertension, edema of pregnancy, premenstrual edema, edema in obesity states, steroid edema.

However, the newer diuretics are probably superior to Hygroton in acute pulmonary edema and the nephrotic syndrome or any condition where the glomerular filtration rate is significantly low.

Geigy

Indications

Hypertension

Such as hypertension with or without congestive failure, where Hygroton can be used alone or in conjunction with other agents

(*Precaution:* Antihypertensive therapy with Hygroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension.)

Edema

Such as edema associated with:
congestive heart failure
or renal disease
(*Precaution:* Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises.)
or hepatic cirrhosis
(Hypoproteinemia, if present, must be corrected concomitantly. *Precaution:* Take special care: discontinue if liver dysfunction is aggravated, since hepatic coma may be precipitated.)
or steroid administration
or obesity
or the premenstrual syndrome
or pregnancy, including toxemia
(*Warning:* Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult, e.g. thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc., are potential problems in the newborn.)

Contraindications

Severe Renal or Hepatic Disease and Demonstrated Hypersensitivity

Other general warnings, precautions and adverse reactions

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Precautions: Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in severe ischemi heart disease and in patients receiv corticosteroids, ACTH, or digitalis. Salt restriction is not recommended

Adverse reactions: Nausea, gastric irritation, vomiting, anorexia, consti pation and cramping, dizziness, wea ness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thromb cytopenia, agranulocytosis, dysuria impotence, transient myopia, skin rashes, urticaria, purpura, necrotizi angiitis, acute gout, and pancreatiti when epigastric pain or unexplaine G.I. symptoms develop after prolong administration. Other reactions reported with this class of compoun include: jaundice, xanthopsia, paresthesia, and photosensitization

Average Dosage: 50-100 mg. with breakfast daily.

Availability: White, single-scored tablets of 100 mg. and aqua tablets 50 mg. in bottles of 100 and 1000.

Please see full Prescribing Informat

Geigy Pharmaceuticals
Division of Geigy Chemical Corporati
Ardsley, New York 10502

In Memoriam

HENRY BUNCH, M.D.
Williamsburg
1924-1967

Henry Bunch, M.D., a general practitioner, died August 6 at the Southeastern Kentucky Baptist Hospital. Death was attributed to a heart attack. Doctor Bunch practiced in Williamsburg for eight years following his graduation from the University of Louisville School of Medicine in 1958 and a year of internship at St. Elizabeth Hospital, Dayton, Ohio.

MARION O. CROWDER, M.D.
Owensboro
1908-1967

Marion O. Crowder, M.D., 59, a surgeon who had practiced in Owensboro for 20 years, died July 20 at the Owensboro-Daviess County Hospital after a long illness. Doctor Crowder graduated from the University of Louisville School of Medicine in 1931. He was a fellow of the American College of Surgeons.

CLARENCE H. LIKINS, JR., M.D.
Louisville
1922-1967

Clarence H. Likins, Jr., M.D., 44, an anesthesiologist, died of cancer August 6 at St. Anthony Hospital. Doctor Likins, a 1945 graduate of the University of Louisville School of Medicine, was a past president of the Louisville and Kentucky Associations of Anesthesiologists and a fellow of the American College of Anesthesiologists. He was a member of the International College of Physicians and Surgeons.

Special Article

(*Continued from Page 875*)

(Commonly Utilization Review Committee Function)

iv) Surveillance of inadvertent hospital infection potentials and cases and the promotion of a preventive and corrective program designed to minimize these hazards;
(Commonly Infection Committee Function)

v) Surveillance of pharmacy and therapeutic policies and practices within the institution to assure optimum utilization with a minimum potential for hazard.
(Commonly Pharmacy and Therapeutics Committee Function)

Clearly then, the Joint Commission has in the past unwittingly fostered the separation of functions relating to patient care.

In summary, I have described "the role of organized medicine in connection with accreditation and its effect on the quality of patient care." The role is clear and present administrative mechanisms or their models exist whereby the accreditation mechanism can more efficiently effect patient care. There are large gaps between organized medicine at the J.C.A.H. level and the hospital. A bridge for this gap is suggested in California. The present organization of hospitals is disjunctive so that there is quality nursing care, quality medical care, and quality administration. The sum of these components do not necessarily add up to quality patient care. I might close by quoting:

"The centipede was happy quite
Until a toad in fun
Said, 'Pray, which leg goes after which?'
That worked her mind to such a pitch,
She lay distracted in a ditch,
Considering how to run."

Screening Tests To Be Available During KMA Annual Meeting

The Kentucky Thoracic Society will sponsor pulmonary ventilation screening tests for physicians during the KMA Annual Meeting September 26-28 at Convention Center, Louisville. The tests will be given by U of L and U of K medical students.

The tests are designed not only as a screening device, but also to interest physicians in the use of pulmonary ventilation screening in their daily practice, according to Hugh S. Fulmer, M.D., Lexington, president of the society.

Physicians who take the test will receive a report of the results and a summary report of the survey's total findings. The screening booth will be just north of the foyer in the Convention Center at the entrance to the technical exhibit hall.

KPA Honors Mr. Grider

The Kentucky Pharmaceutical Association named George Grider, Danville, pharmacist of the year at its annual convention July 25 in Paducah.

Grider is president of the American Pharmaceutical Association and a member of the McDowell Board of Governors.

Vessels Trade Fare for Services

Port Line Ltd., a British Flag carrier with a fleet of 33 vessels, will exchange transportation to Australia or New Zealand for medical services on board ship by doctors interested in returning to those countries after studying in the United States. Interested doctors may contact Port Line Ltd., c/o Funch, Edye & Co., Inc., 25 Broadway, New York, N.Y. 10004, Attn: Mr. L. J. Eble.

Handicapped Week To Be Oct. 1-7

National Employ the Physically Handicapped Week will be observed October 1-7, according to John R. Callaham, chairman of the Business Publications Committee of the President's Committee on Employment of the Handicapped.

Candidates for Mediatric

Commonly heard complaints from your geriatric patients may indicate an underlying disorder that may require immediate attention—and definitive therapy. But, with or without an underlying functional illness, the patients' physical and emotional well-being may be enhanced by adjunctive steroid-nutritional therapy. That's why so many patients just like these are suitable candidates for MEDIATRIC from their very first visit.

"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging...." This therapy resulted in improvement of 75 per cent of the patients.

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

The estrogen component is PREMARIN® (conjugated estrogens—equine), the orally active, natural estrogen most widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain an anabolic balance to forestall premature estrogen-related degenerative changes.

MEDIATRIC also supplies a small amount of *methamphetamine* to provide a gentle mood uplift; and nutritional supplements specially selected to meet the needs of the aging.

MEDIATRIC helps keep the older patients alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, and lack of interest so often associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: **Male and female:** 1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000.

No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon.

Steroid-nutritional compound

	Each MEDIATRIC **TABLET or CAPSULE** contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC **LIQUID** contains:
Conjugated estrogens—equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	–
Thiamine HCl	–	5.0 mg.
Thiamine mononitrate	10.0 mg.	–
Riboflavin	5.0 mg.	–
Niacinamide	50.0 mg.	–
Pyridoxine HCl	3.0 mg.	–
Calcium pantothenate	20.0 mg.	–
Ferrous sulfate exsiccated	30.0 mg.	–
Ascorbic acid	100.0 mg.	–
		(Contains 15% alcohol)

Mediatric® tablets • capsules • liquid

6726

AYERST LABORATORIES • New York, N.Y. 10017 • Montreal, Canada

The Mediatric® Age:

Many patients, with or without a functional illness, show symptoms of an aging metabolism: disinterest... lassitude... vague aches and pains.

Mediatric® can help them lead a more active, useful life.



County Medical Societies Name 1967 Officers

The Kentucky Medical Association had received the names of the 1967 officers of the county medical societies listed below as of August 20, according to the records department.

Knott
President: D. G. Barker, M.D., Hindman
Vice-President: Gene Watts, M.D., Hindman
Secretary: M. F. Kelley, M.D., Hindman
Delegate to KMA: Gene Watts, M.D.
Alternate: M. F. Kelley, M.D.

Lawrence
President: Arthur B. Richards, M.D., Louisa
Secretary: George P. Carter, M.D., Louisa
Delegate to KMA: George P. Carter, M.D.
Alternate: Hobart Lester, M.D., Louisa

Letcher
President: Jim B. Tolliver, M.D., Whitesburg
Vice-President: John E. Engle, M.D., Whitesburg
Secretary-Treasurer: Carl Pigman, M.D., Whitesburg
Delegate to KMA: Jim B. Tolliver, M.D.
Alternate: Lundy Adams, M.D., Blackey

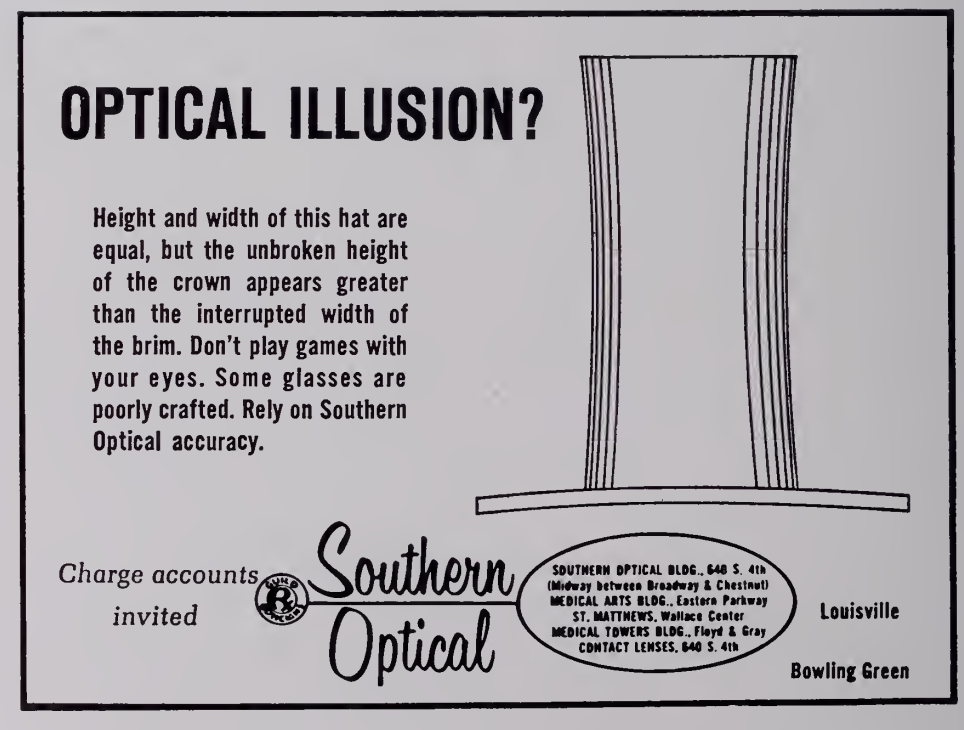
Menifee
Delegate to KMA: D. L. Graves, M.D., Frenchburg
Alternate: C. M. Brand, M.D., Jeffersonville

Nicholas
President: Van Jenkins, M.D., Carlisle
Vice-President: J. T. Morford, M.D., Carlisle
Secretary-Treasurer: W. R. Kingsolver, M.D., Carlisle
Delegate to KMA: W. R. Kingsolver, M.D.
Alternate: Van Jenkins, M.D.

Powell
President: John Knox, M.D., Stanton
Vice-President, Secretary-Treasurer: Charles Noss, M.D., Stanton
Delegate to KMA: Charles Noss, M.D.
Alternate: John Knox, M.D.

Pulaski
President: William T. Watkins, M.D., Somerset
Vice-President: Barton L. Ramsey, M.D., Somerset
Secretary-Treasurer: Michael D. Thomas, M.D., Somerset
Delegates to KMA: William M. Wyatt, M.D., Somerset
Barton L. Ramsey, M.D.

Simpson
President: L. F. Beasley, M.D., Franklin
Vice-President: Carter Moore, M.D., Franklin
Secretary-Treasurer: A. V. Wilwayco, M.D., Franklin
Delegate to KMA: Airzzie Green, M.D., Franklin



The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



NAPOLÉON BONAPARTE *LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!*

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.

GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.



THE BOOK ***"PRAY YOUR WEIGHT AWAY"*** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

**SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).*

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

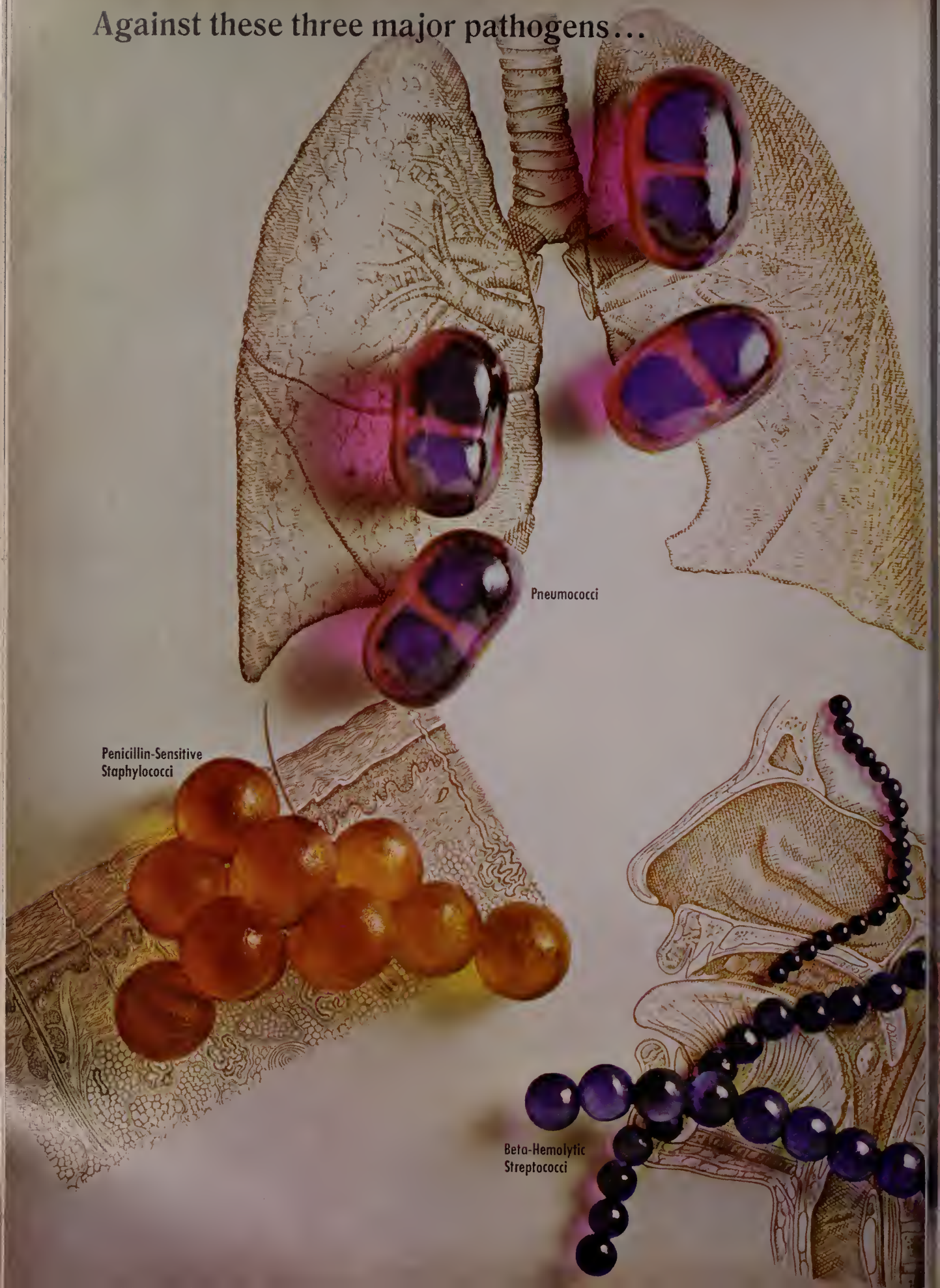
One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

Against these three major pathogens…



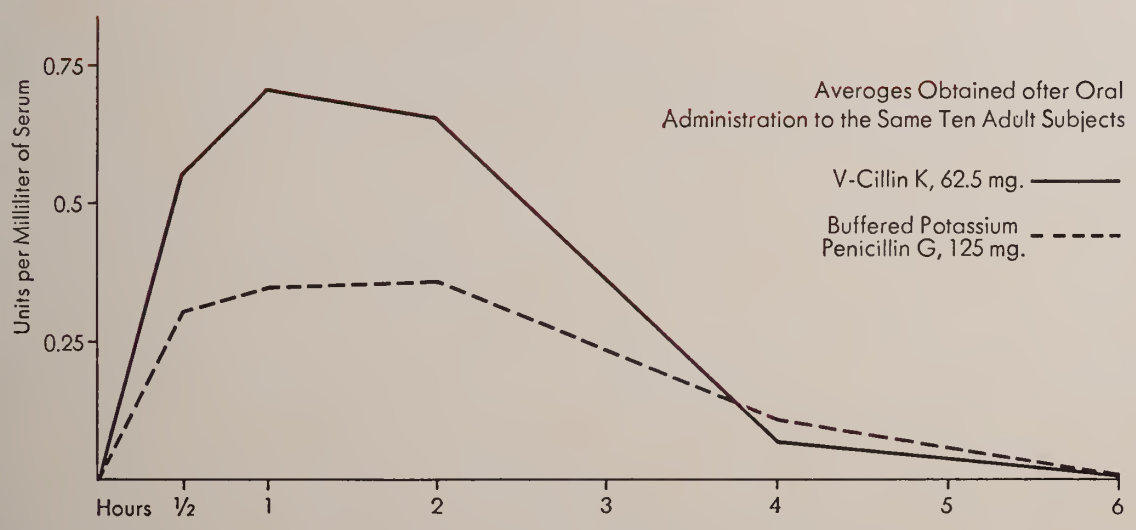
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Stoph.Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxocillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets... a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with h parenteral dosage schedules, frequent evaluation of the renal c hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stuc (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration sho be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much l common with administration of oral penicillin than with intramuscu forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sigr cant index of sensitization. The following hypersensitivity reactic associated with the use of penicillin have been reported: skin rasl ranging from maculopapular eruptions to exfoliative dermatitis; u caria; and reactions resembling serum sickness, including chills, fev edema, arthralgia, and prostration. Severe and often fatal anaphylc has occurred (see Warnings). Hemolytic anemia, leukopenia, thrc bocytopenia, and nephropathy are rarely observed side-effects c are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin Pediatric, the usual dosage ranges from 125 mg. (200,000 units) thi times a day to 500 mg. (800,000 units) every four hours. For infar the daily dosage may be 50 mg. per Kg. of body weight divided i three doses.

Beta-hemolytic streptococcus infections without associated b teremia may be treated with 200,000 to 400,0000 units three time day. Therapy should be continued for a minimum of ten days to prev development of rheumatic fever and/or other serious complicatio Dosage for routine streptococcus prophylaxis in patients with a hist of rheumatic fever or congenital heart disease may be 200,000 u once or twice daily. When such patients undergo tonsillectomy, to extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the c of surgery, parenteral therapy should be considered. Mild to moc ately severe pneumococcus pneumonia has been treated effectiv with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be gi every six to eight hours in conjunction with indicated surgical pro dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours three doses may be employed; in females, 500 mg. every four ho for six doses are recommended. Refractory infections generally respc to a second treatment three to four days following completion of first. Treatment of gonorrhea with severe complications should individualized, with prolonged and intensive treatment. Patients witl suspected lesion of syphilis should have a dark-field examination l fore receiving penicillin and monthly serologic tests for a minimum three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 n (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) p 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032C

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

NEWS ITEMS

John M. Stoeckinger, M.D., a surgeon, is now practicing in association with David Hull, M.D., and Gordon Hyde, M.D., in Lexington. Doctor Stoeckinger graduated from the University of Louisville School of Medicine in 1962.

Harry O. DeBandi, M.D., is now associated with the Trover Clinic, Madisonville, limiting his practice to urology. Doctor DeBandi practiced previously in Memphis.

W. E. Waltrip, M.D., an anesthesiologist, has opened an office in Owensboro. Doctor Waltrip graduated from the University of Louisville School of Medicine in 1960 and practiced general medicine previously at the Trover Clinic, Providence.

Harry B. Huntsman, M.D., a general practitioner, has entered practice in Greensburg in association with George C. Cheatham, M.D. Doctor Huntsman graduated from the University of Louisville School of Medicine in 1966.

E. M. Kalb, M.D., is now on the staff of Murray State University, Murray. Doctor Kalb, a general practitioner, previously practiced in Indianapolis.

Leslie E. Karr, M.D., a 1966 graduate of the University of Louisville School of Medicine, is now practicing in association with Elmer Prewitt, M.D., in Corbin.

Kirk Bowman, Jr., M.D., is now practicing in association with the Trover Clinic, Madisonville, limiting his practice to internal medicine and cardiology. Doctor Bowman graduated from the University of Tennessee School of Medicine in 1960.

William G. Wheeler, Jr., M.D., an orthopedic surgeon, is now practicing in Lexington in association with O. B. Murphy, M.D., T.D. Yocum, M.D., and G. M. Gumbert, M.D. Doctor Wheeler graduated from Vanderbilt University School of Medicine in 1960.

Harold Thomas Faulconer, M.D., has opened an office in Lexington, limiting his practice to vascular and general surgery. Doctor Faulconer graduated from the University of Louisville School of Medicine in 1958.

Leslie Van Nostrand, M.D., a psychiatrist, is now associated with John Bell, M.D., Frank Gaines, M.D., Hollis Johnson, M.D., Harvey St. Clair, M.D. and Sandor Klein, Ph.D., in Louisville. Doctor Van Nostrand served as medical director for the Major Appliance Division of General Electric from 1959 to 1964.

Jesse H. Meredith, M.D., a 1966 graduate from the University of Louisville School of Medicine, is now practicing in association with D. C. Bennett, M.D., and R. T. Johnson, M.D., in Beaver Dam.

Frank E. Reeder, M.D., a surgeon, is now practicing in association with William H. Hosbach, M.D., in Paducah. Doctor Reeder formerly practiced in Memphis for five years.

Roy R. Bontrager, M.D., is now associated with the Daniel Boone Clinic, Whitesburg, limiting his practice to general medicine. Doctor Bontrager graduated from Ohio State University Medical School in 1966.

Mary L. Osborne, M.D., is now associated with W. P. Peak, M.D., and Frank W. Lehn, M.D., Louisville, limiting her practice to rheumatology. Doctor Osborne graduated from the University of Louisville School of Medicine in 1963.

D. E. Wood, M.D., Auburn, began a tour of duty with the Medical Corps of the U.S. Navy August 1. He plans to return to Auburn when his service is completed.

John A. Logan, M.D., closed his office in Sebree July 22, according to a recent press report. Doctor Logan planned to be associated with Kenneth M. Eblen, M.D., Henderson, effective August 1.

D. C. Bennett, M.D., a general practitioner, is now associated with Robert Johnson, M.D., and Jesse Meredith, M.D., in Beaver Dam. Doctor Bennett had practiced previously in Beaver Dam from 1955 to 1962 and has more recently been in practice at Owensboro.

J. Wesley Johnson, M.D., a surgeon, is now practicing in association with Gerald B. Reams, M.D., Ashland. Doctor Johnson graduated from the University of Louisville School of Medicine in 1960.

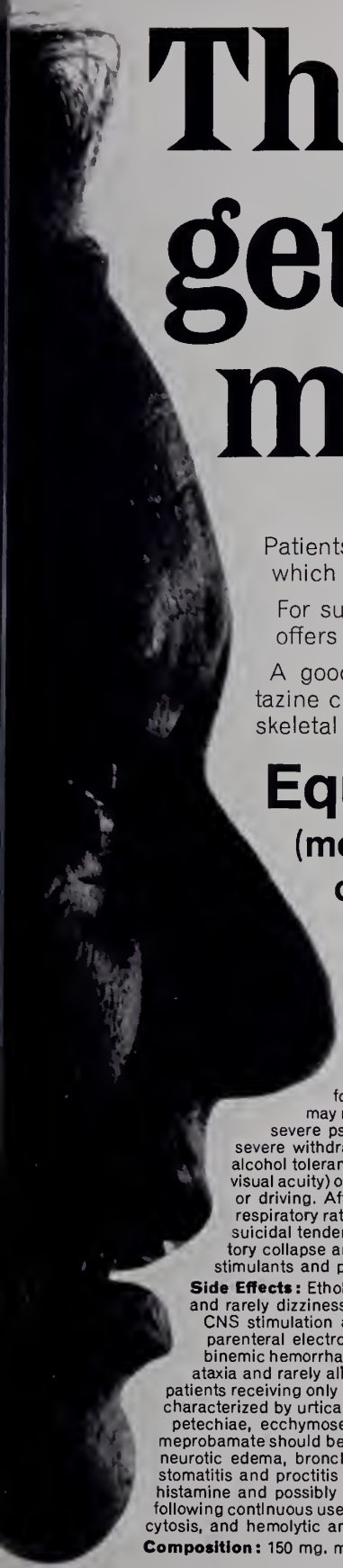
William T. Moore, M.D., an otolaryngologist, is now practicing at Happy Valley Center, Glasgow. Doctor Moore graduated from the University of Louisville School of Medicine in 1962.

Virginia Wallace, M.D., will return to Irvine this fall to practice in the new Estill County Medical Clinic, according to a recent press report. Doctor Wallace had practiced in Irvine for 28 years before serving as health officer in Madison County for 18 months.

Robinson P. Kirkpatrick, M.D., has opened an office in Danville, limiting his practice to anesthesiology. Doctor Kirkpatrick had practiced for six years in Cincinnati previously.

Thomas E. Averitt, M.D., has left Winchester where he practiced for 19 years to practice in Thomson, Georgia.





This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

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(meprobamate and ethoheptazine citrate with aspirin)

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Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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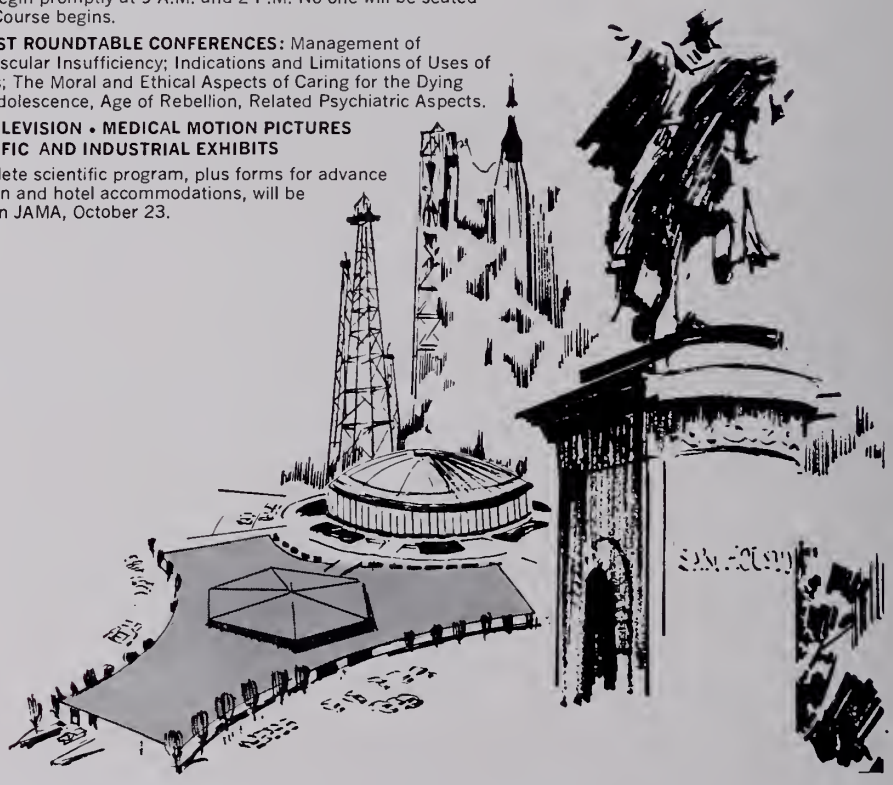
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when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoidir those responsive to routine measures as well as contraindicated p tients. Obtain a detailed history and a complete physical and laborato examination, including a blood count. The patient should not exce recommended dosage, should be closely supervised and should b warned to discontinue the drug and report immediately if fever, so throat, or mouth lesions (symptoms of blood dyscrasia); sudden weig gain (water retention); skin reactions; black or tarry stools or oth evidence of intestinal hemorrhage occur. Make regular blood count Discontinue the drug immediately and institute countermeasures if th white count changes significantly, granulocytes decrease, or immatu forms appear. Use greater care in the elderly and in hypertensive

Adverse Reactions: The most common are nausea, edema and dru rash. Swelling of the ankles or face may be minimized by withholdin dietary salt, reduction in dosage or use of diuretics. In elderly patient and in those with hypertension the drug should be discontinued wit the appearance of edema. The drug has been associated with peptic ul

or 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the gonizing pain of shoulder bursitis.

's not for every patient. Check carefully the Contraindications, Warning and recautions shown below.

nd adverse reactions may occur. The most common are nausea, edema and rash. arely, agranulocytosis has been reported. All adverse reactions are listed below, too.

lay-for-pay or workaday patients—when they come up with shoulder bursitis and your linical judgment indicates Butazolidin alka—go with it.

nd watch the comeback.



er and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur. 6509-V(B)R2

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100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
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Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

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Answers To Your Questions About Blue Cross-Blue Shield-65

Q. How many Kentuckians have enrolled in the Blue Cross-Blue Shield-65 supplementary plan?

A. About 42,000.

Q. I understand that the annual $100 deductible for the Extended Benefits portion of the plan has been reduced to $50. Is this correct?

A. Yes. This was made at no extra cost to the member retro-active to July 1, 1966.

Q. How can my secretary identify Blue Cross-Blue Shield-65 members?

A. By looking at their Identification Card which contains Blue Shield coverage code 95-95.

Q. Should we complete and submit to Blue Shield a regular Physicians' Service Report when professional services are rendered Blue Cross-Blue Shield-65 members?

A. No. These members have been provided a special claim form #441 which they have been instructed to complete, attach itemized statements for covered services and forward to Blue Shield's Louisville office. Due to the deductibles and co-insurance involved and the different providers of service, payments are made directly to the member.

Q. Are there any Blue Shield members 65 or older for whom we should bill Blue Shield directly using the regular Physicians' Service Report?

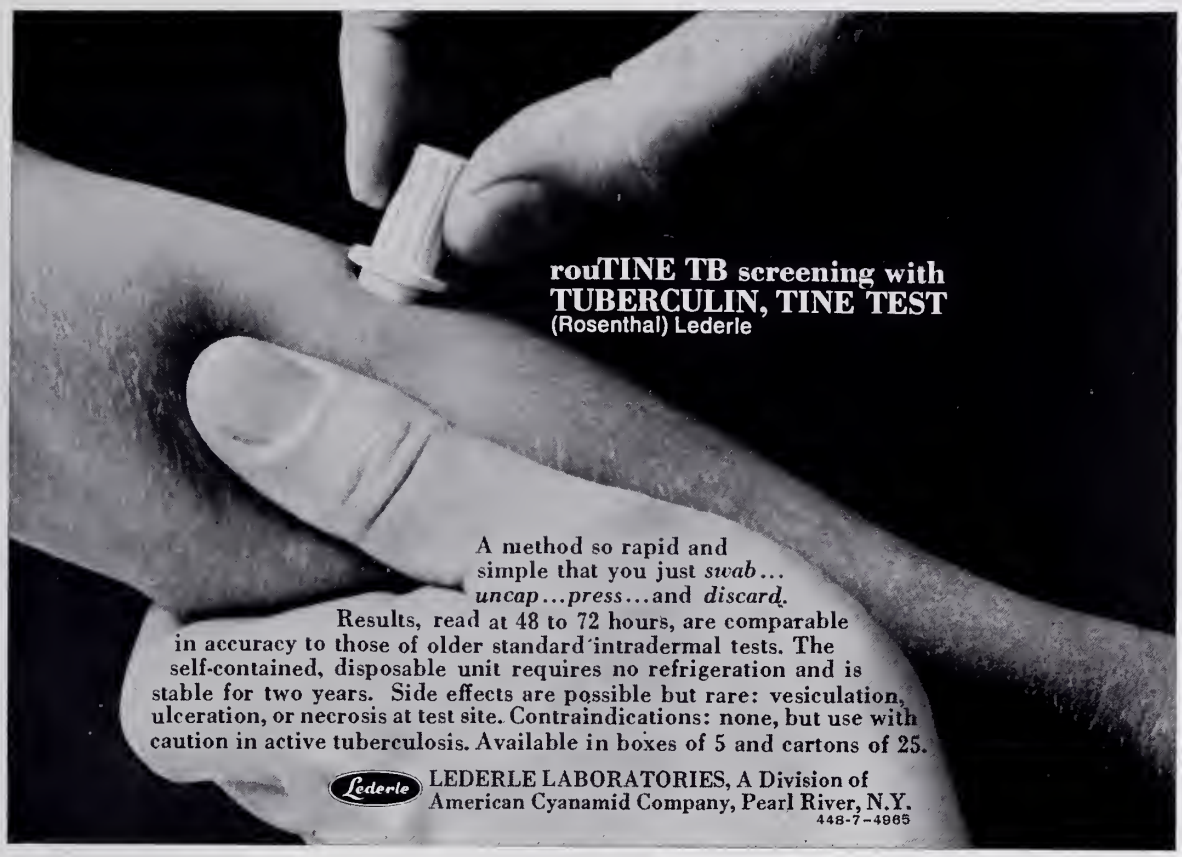
A. Yes. Physicians are requested to bill Blue Shield in the usual manner whenever the over 65 patient's Identification Card contains Blue Shield COVERAGE CODE 98-98 or GROUP NUMBER 9068. Allowance will be paid direct to the physician.

Q. Does the Blue Cross-Blue Shield-65 member have to submit paid receipts to Blue Shield in order to receive his benefit allowances?

A. No. Only itemized statements need to accompany the completed BC-BS-65 Claim Form #441.

Q. Can Blue Cross-Blue Shield-65 members obtain claim forms at any Blue Cross and Blue Shield business offices in Kentucky?

A. Yes. Offices are located in Ashland, Bowling Green, Covington, Frankfort, Lexington, Owensboro, Somerset and Paducah. They are open from 8:00 a.m. to 4:30 p.m. daily except Saturdays, Sundays and holidays.



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Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

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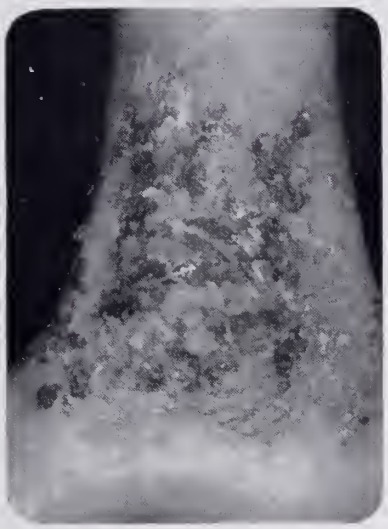
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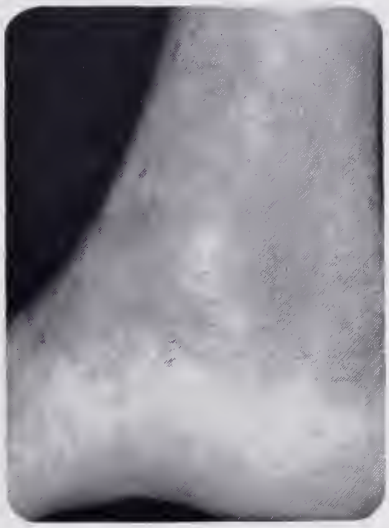
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Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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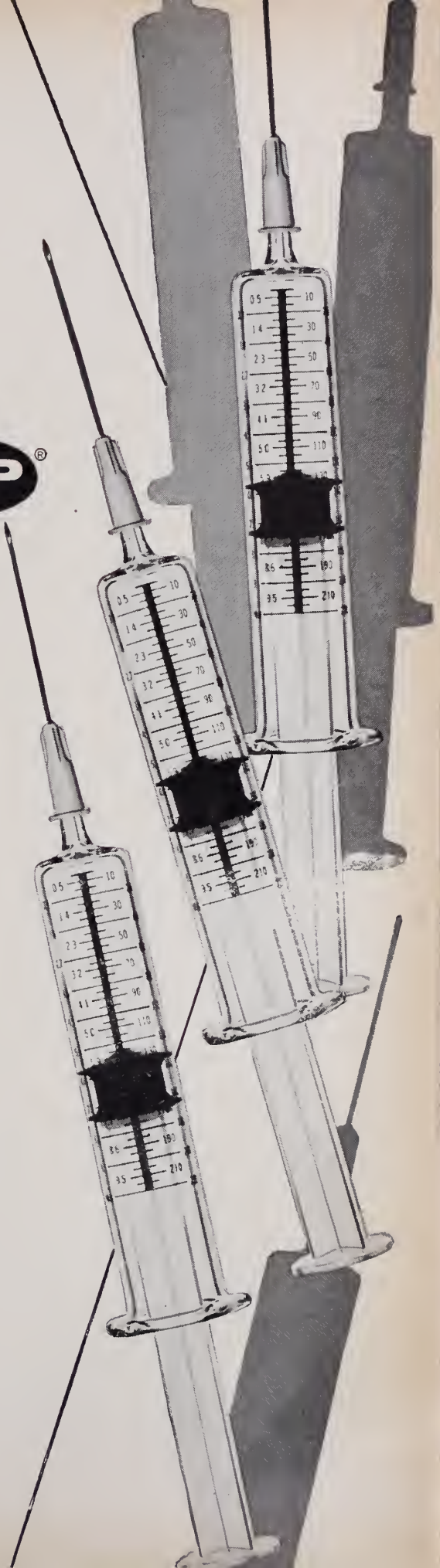


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JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

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MESSAGE FROM THE PRESIDENT



THE AMPAC Workshop in Washington recently showed clear-cut national recognition of Kentucky as leading the PAC movement of physicians as active citizens. Hoyt D. Gardner, M.D., our AMPAC Trustee, had star billing as the moderator of the featured panel of two senators and two congressmen. The entertainment for the Saturday night dinner was a floor show by the KEMPAC Kuties composed of Mesdames Holmes, Barton, Pitman, Smith, Wells, Hamilton and Scott of the Medical Auxiliary of Whitley County.

KEMPAC is leading again this year—into candidate support in the local races. This is good. Too many, both in and out of medicine, have regarded KEMPAC as a branch of the Republican Party. This arises because, in national issues, the Democrats as a party have taken positions medicine as a whole could not support. Actually, KEMPAC is an arm of KMA, and, like KMA, is bi-partisan. Your Legislative Council and KMA Trustees, Republican or Democrat as they may be, appoint your KEMPAC Directors, Republican or Democrat as they need to be.

In supporting local candidates, we will be seeking men who remember the fundamentals of our national greatness—the men who believe in:

Honesty, in personal life and in government.

The constitutional freedoms of citizenship—freedom of speech and thought, freedom of worship and suffrage.

The inherent rights of the individual—to initiative, to the joy of work, and to the peaceful possession of the fruits of his labor.

Men who hold these beliefs rise above party. Who remembers the party label of George Washington or Thomas Jefferson, Andrew Jackson or Abraham Lincoln?

If we can elect dedicated Americans we need have no fear of big government, socialism, or socialized medicine.

George F. Brockman



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

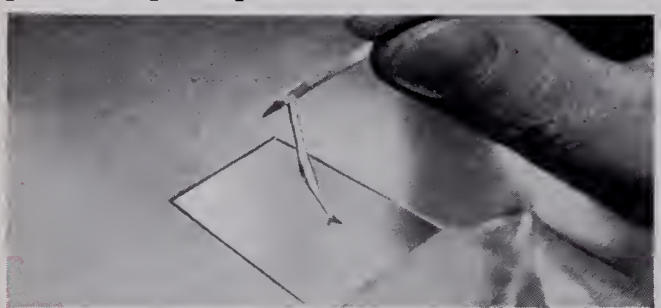
But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

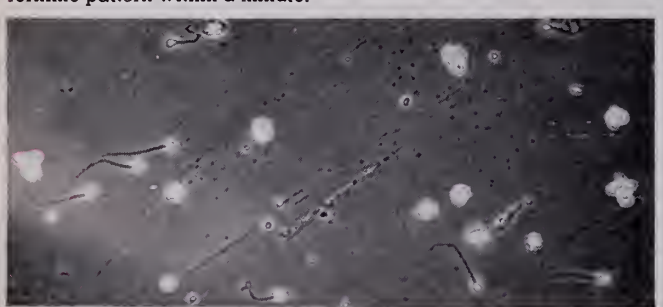
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

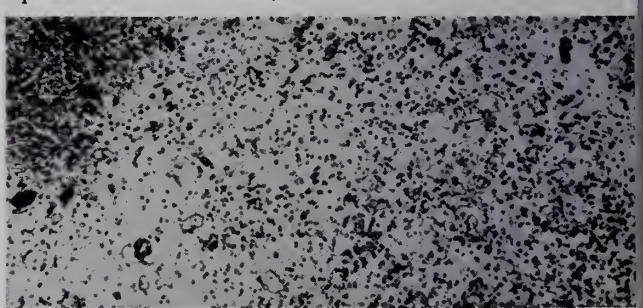


Spermatozoa appear healthy, are active and freemoving.

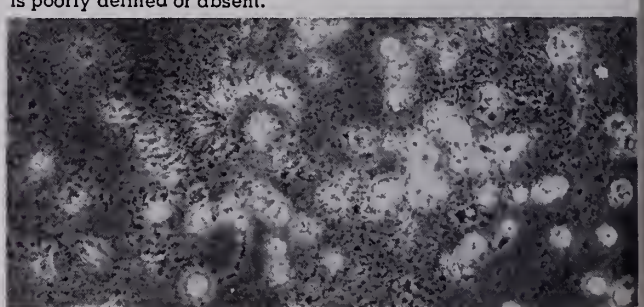
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

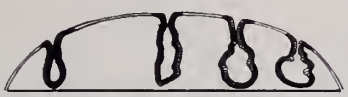


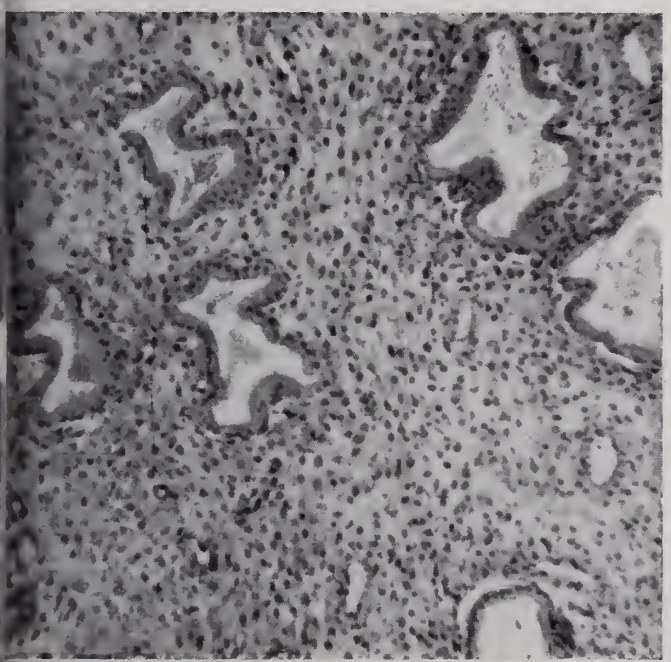
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient

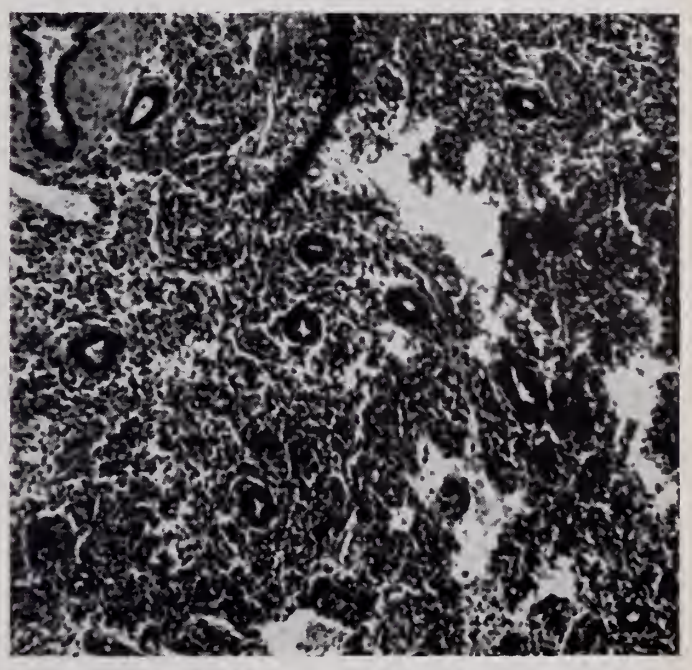




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

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See last page for contraindications, precautions, side effects and dosage.

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Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

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DISORDERS OF THE RESPIRATORY TRACT IN CHILDREN: edited by Edwin L. Kendig, Jr., M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1967; 834 Pages; Price, $26.00.

Although quite a few books regarding specific disorders of the respiratory tract have been written, this volume represents the first attempt by a distinguished pediatrician and 28 other authorities to write a comprehensive textbook on pediatric respiratory diseases. It will become a welcome addition to libraries of those who care for infants and children and, hopefully, future editions will continue.

The book begins with an extremely good chapter, "The Functional Basis of Respiratory Pathology," and extends to a total of 67 chapters in 11 sections. The entire upper and lower respiratory tracts are discussed which contributes to considerable repetition. Although such over-fragmentation lends the book encyclopedic value, some old and new diseases, e.g., Wilson-Mikity syndrome, aberrant thyroid and other inclusions in the tongue, inclusion cysts of uvula and oropharynx, the dysgammaglobulinemias associated with bronchiectasis, etc. are not mentioned. Therapy was not given emphasis in some expected areas and controversial areas were avoided.

Chapters which will be of greatest value to many students of chest diseases are those written by Doctor Kendig on tuberculosis, sarcoidosis, mycobacterias, etc.; the chapters on "History and Physical Examination" and "Diagnostic and Therapeutic Procedures."

The volume certainly represents much information and material beyond the scope of general pediatric texts and we are indeed grateful for the endeavors of Doctor Kendig and his associates.

BILLY F. ANDREWS, M.D.

LECTURES TO RELATIVES OF FORMER PATIENTS: by Abraham A. Low, M.D.; Published by The Christopher Publishing House, Boston, 1967 (Originally published in paperback form in 1943); 229 Pages; Illustrated; Price, $5.00.

These lectures are the forerunners of the theories which led Doctor Low to found "Recovery Inc.", a self help, group therapy system for emotionally ill persons.

The basic idea behind the book is sound; i.e., discharged psychiatric patients need continuing understanding and help from their families to stay well. Doctor Low's lectures abound in simple homely examples of problems and suggested solutions without psychiatric jargon. However, since it is directed to families of patients, it is *so* non-technical that it greatly over-simplifies the process of behavior control by means of education and will power. It's almost as if he is saying "Trying will overcome all" or "Mind over matter". Unfortunately, it's much more complex than this with most of us.

Many patients ask about the usefulness of "Recovery Inc.". This book can help the physician to advise whether specific patients would find it helpful.

FRANK M. GAINES, M.D.

SYNOPSIS OF PEDIATRICS, Second Edition: by James C. Hughes, M.D.; Published by The C. V. Mosby Company, St. Louis, 1967; Price, $10.85.

The title of this book, *Synopsis of Pediatrics,* is most applicable. It consists of 27 chapters written by a total of 28 authors. It should in no way be considered a substitute for a standard textbook of pediatrics. The purpose of the authors is to select and discuss only the fundamentals of the most important aspects of pediatrics, and, thereby, exclude many subjects which in their opinion were of less significance. As a result, the physician's favorite diseases may be omitted from the textbook.

Many of the chapters are devoid of references. There are a minimum number of photographs or x-rays of patients presenting disease entities. In the section on cardiovascular disease, no electrocardiograms are reproduced and the subject of cardiac catheterization is barely mentioned. The authors utilize a new method of medical illustration which consists of an organ, arrow and label overlays superimposed upon a diagram of the patient.

As a substitute title for *Synopsis of Pediatrics,* the word "handbook" is believed applicable.

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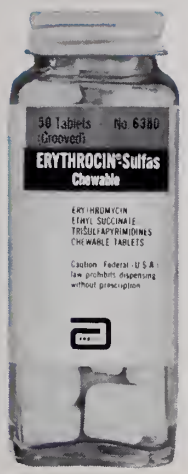
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A clinical cure rate of 94.5%

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87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

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A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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19-21 Southeastern Chapter, Society of Nuclear Medicine, Phoenix Hotel, Lexington

NOVEMBER

10-11 1967 Postgraduate Course in Surgery, University of Kentucky College of Medicine, Lexington

17-18 Kentucky Thoracic Society, Fall Case Conference, Boone Tavern Hotel, Berea

IN SURROUNDING STATES

OCTOBER

11-12 Indiana State Medical Association, Murat Temple, Indianapolis

12-13 "Head and Neck Radiology Conference," University of Illinois Medical Center, Chicago

14-20 Annual Otolaryngologic Assembly, Illinois Eye and Ear Infirmary, Chicago

21-26 American Academy of Pediatrics, Washington Hilton, Washington, D.C.

29 American Association of Ophthalmology, Palmer House, Chicago

29—Nov. 1 American College of Gastroenterology, 32nd Annual Convention, Biltmore Hotel, Los Angeles, California

NOVEMBER

6-10 "Clinical Cardiopulmonary Physiology," American College of Chest Physicians Postgraduate Program, Knickerbocker Hotel, Chicago

6-17 Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary, Chicago

8-9 Cleveland Clinic Educational Foundation postgraduate course, "Problems in Pelvic Surgery," Bunts Auditorium, Cleveland

13-17 "Diagnosis and Treatment of Diseases of the Heart and Lungs," American College of Chest Physicians Postgraduate Program, Barbizon-Plaza, New York City.

15-16 Cleveland Clinic Educational Foundation postgraduate course, "Pain: Neurological and Neurosurgical Aspects," Cleveland

15-18 American College of Physicians, Postgraduate Course, "Neurologic Aspects of Internal Medicine," Duke University Medical Center, Durham, North Carolina

26-29 American Medical Association's Clinical Convention, Astro Hall, Houston

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Educational Opportunities" calender in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

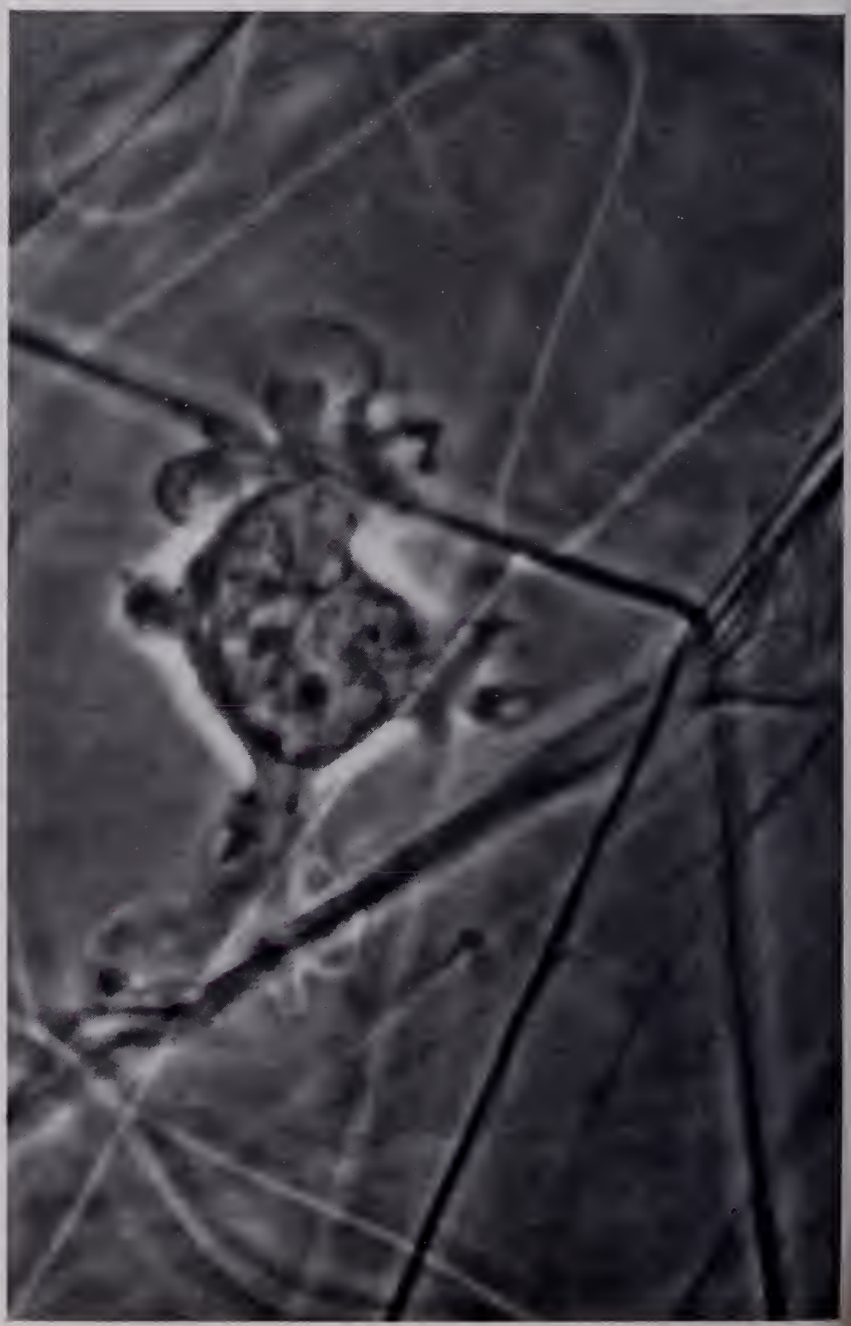
Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

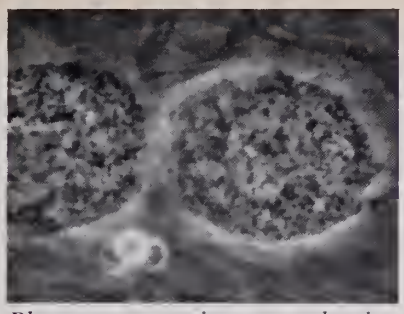


Visual evidence of how corticosteroids influence the inflammatory reaction

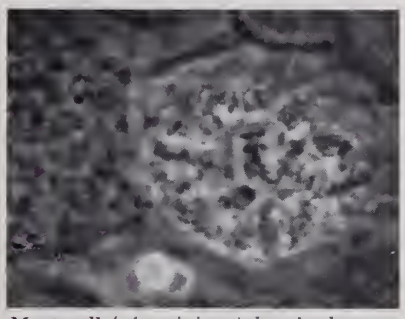
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



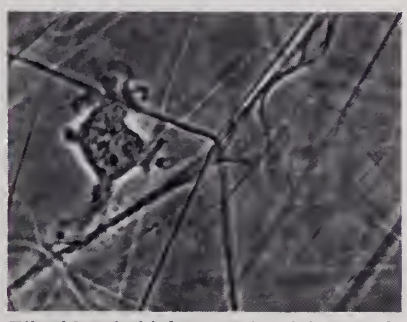
Phase-contrast microscopy showing mast cell before injury.



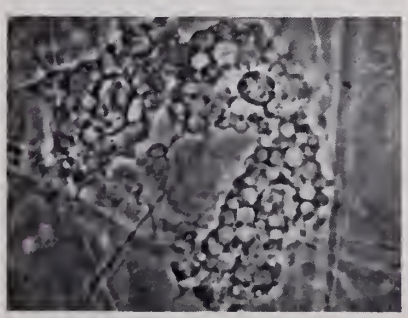
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

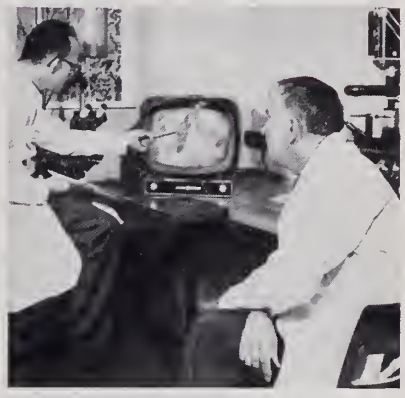
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses*, a film based on this study, is now available from your Syntex representative.

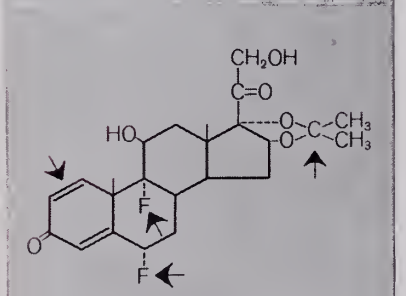
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

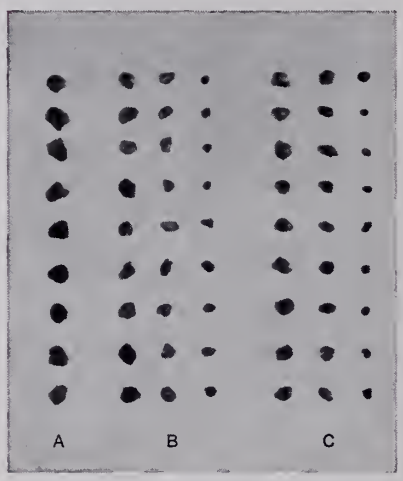


Fluocinolone Acetonide (Synalar)

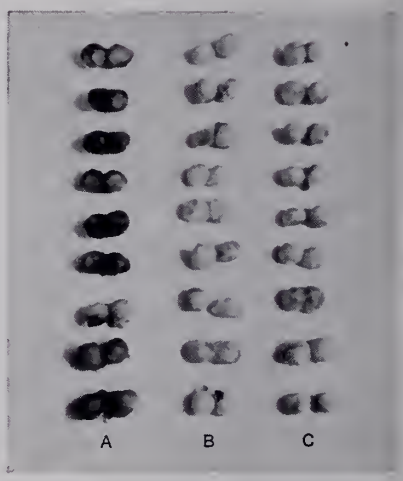
- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Bornman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory dermatoses... by any measure a topical corticosteroid of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE 4-66. This 33 year old married white gravida 3 para 1 ab 1 was under the care of a private physician. Her expected date of delivery was April 15, 1966. The patient had undergone dilatation and curettage in 1954. She was delivered of a normal female infant in 1966. Her prenatal course during the present pregnancy was normal. She was Rh negative, with consistently negative antibody titer. The patient was a known epileptic and regularly took maintenance doses of Dilantin.

At 12:30 P.M. on March 15, 1966, the patient's membranes ruptured at home. She remained there until evening and was then admitted to the hospital for observation. There was no spontaneous labor in the ensuing 24 hours. Intramuscular doses of penicillin were prescribed. The uterus appeared enlarged to a size compatible with an 8 months' gestation. The cervix was long and patulous to 1 cm; it was difficult to palpate vaginally. Because of the condition of the cervix, the patient was sent home with a prescription for an oral antibiotic preparation.

On March 19, 1966 the patient had a hard chill; her physician admitted her to another hospital. The antibiotic was changed from penicillin to chloromycetin. The temperature was 102.2°, pulse 120, respirations 22, and blood pressure 104/68. The fetal heart beat was counted at 168 in the right lower quadrant. The patient continued to experience chilly sensations, and aspirin was ordered together with chloromycetin.

The patient was examined at 7:30 A.M. on March 19, 1966 by her physician. Foul-smelling amniotic fluid continued to leak from the cervix, and the patient complained of a backache. At 9 A.M., she was still suffering from chills. Her temperature was 100°. An obstetrical consultant was called and his impression was that the principal problem was one of amnionitis. The recommendation was to continue the antibiotics and terminate the pregnancy with a pitocin infusion. The infusion was started at 10 A.M. at a rate of 16 drops per minute after she had been transferred to the delivery area. Contractions were soon occurring at two to three minute intervals. Smear and culture of the amniotic fluid were obtained; they showed gram negative rods resembling Pasteurella. Since chills continued to occur, a blood culture was ordered; in the meantime, the pitocin infusion was continued. At 11:30 A.M. the cervix was completely dilated, the first stage of labor having lasted approximately 12 hours. She was moved to the delivery room; in the ensuing 30 minutes she had several shaking chills. Blood was drawn for another culture. Saddle block anesthesia was administered, and the patient was prepared for delivery.

Over a midline episiotomy a stillborn male infant weighing 6 lb. 6 oz. was delivered by outlet forceps at 12:01 P.M. Autolytic skin changes indicated that the baby had died *in utero* some time before delivery. The placenta was manually removed at 12:09 P.M. with some difficulty. The patient continued to have shaking chills throughout the delivery procedure. After the placenta had been removed, a swab of the uterine cavity was taken for bacteriologic culture. There were no lacerations of the cervix or vagina nor any extension of the episiotomy, which was repaired in the usual manner. The patient continued to have chills, and her temperature rose to 104° rectally. Her lips became cyanotic, and her face and body became dusky red. Her blood pressure dropped from 110/105 to 90/60. A medical consultant was called and arrived 30 minutes later. When he arrived the situation had not changed. He concurred with the clinical diagnosis of acute septicemia, although the specific organism responsible had not been identified by any of the laboratory procedures undertaken to this point. A portable chest film made in the delivery room showed no abnormalities except for a questionable increase in prominence of the lung markings.

The patient was transferred to the intensive care unit, an intravenous infusion of 5 per cent dextrose in water was started and Keflin was added in addition to the previously ordered antibiotics. An order to start Levophed was contingent upon a blood pressure drop to below 80. A Foley catheter was inserted. The blood pressure on arrival in the intensive care unit was 94/60; the pulse rate was 160, and the pulse was weak and thready. The uterus was palpable two finger breadths below the umbilicus and there was a small amount of vaginal bleeding. The rectal temperature was 103.4°. The blood pressure dropped to 78/40, but soon became stabilized at 100/60; the tachycardia gradually slowed, but the urinary output was scant. Levophed was added to the intravenous fluids. The fluid intake was 1900 cc for the first eight hours postpartum, but the urinary output was only 50 cc. An electrocardiographic tracing was normal except for sinus tachycardia.

An unidentified organism cultured from material collected on the day of delivery was reported to be resistant to Keflin, penicillin and polycillin and sensitive to chloromycetin, Kantrex and Furadantin. The Keflin was discontinued on March 20 and 1 gram of chloromycetin was given intravenously at 11:30 P.M. A plain film of the chest taken on March 20 showed slight enlargement of the heart, together with infiltrates in the medial portions of the lung fields compatible with acute pulmonary edema. A portable plain film of the abdomen showed gas in the stomach and colon. No free air was present. Shortly after

(Continued on Page 1025)

A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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VOLUME 65 October 1967 No. 10

Hemodynamics of Congenital Heart Disease

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A simplified discussion of the hemodynamics enables the physician to make a clinical diagnosis and be practical in the management of patients with heart lesions.

CONGENITAL heart disease results in an alteration of the hemodynamics of the normal circulation. Medical students today understand these altered hemodynamics which were mysteries a decade ago and were in the realm of research. The availability of specialized equipment and techniques which were non-existant prior to 1957-1958 are now daily routine procedures in cardiac catheterization laboratories. As a result of the advances in the diagnosis and understanding of the hemodynamics of congenital heart lesions there has been a concomitant progress in the surgical management permitting complete repair or emergency palliation. Determination of pressures, oxygen saturation, the presence of right-to-left or left-to-right shunts by the use of indicators (photospectrometric, isotopes, hydrogen-platinum electordes, inhalation of inert gases) has become standard procedure. Left heart catheterization utilizing a transeptal puncture of the atrial septum has been utilized since 1959 and the left ventricle may also be entered by percutaneous puncture and by retrograde catheterization of the aorta. Measurements of pressure in the left heart chambers, oxygen saturations and the pathways of indicator substances injected into the left heart chambers and great vessels have resulted in an understanding of congenital lesions and the hemodynamics of the systemic and pulmonary circuits, flow pressure and resistances. Angiocardiography demonstrates structural abnormalities, and anomalies producing veno-arterial shuntings can be visualized. Peripheral venous angiocardiography has been superceded by selective injection into specific chambers of the heart employing cineangiocardiography techniques resulting in as many as 60 frames per second, and contraction of the heart in systole and relaxation in diastole visualizes the direction of blood flow which is no longer a matter of conjecture.[1]

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Classification

In the standard textbooks and literature one finds numerous classifications of Congenital Heart Disease.[2-3] The following classification is believed to be simple, practical and readily understood.

I. Communication between the systemic and pulmonary circulation with a dominant pulmonary blood flow.
II. Obstructive lesions without communications between the systemic and pulmonary circulation.
III. Non-obstructive valvular lesions.
IV. Communication between the systemic and pulmonary circulation with a dominant systemic blood flow.
V. Lesions in which there is a common mixing chamber.
VI. Transpositions of the Great Vessels.

I. *Communications between the systemic and pulmonic circuits with pulmonary flow greater than systemic (pulmonary recirculation: "left-to-right" or arteriovenous shunt).* These lesions include atrial septal defect, anomalous drainage of a pulmonary vein into the right atrium, atrioventricular canal, ventricular septal defect, anomalous left coronary artery, truncus arteriosus, sinus of Valsalva fistula and aortic pulmonary communications (aortic pulmonary windows or patent ductus arteriosus). The increased pressures in the left heart chamber produce a left-to-right shunt through these defects and, with the exception of truncus arteriosus, they are categorized as acyanotic lesions. Significant murmurs result from turbulence of flow through the defect in high pressure shunts, or by increased pulmonary blood flow in atrial septal defects. The continuous murmur in systole and diastole is characteristic of an aorticpulmonary artery communication and results from the usual pressure difference existing between these two vessels in systole and diastole. A wide pulse pressure and a prominent peripheral pulse are due to the blood flow from the aorta into the pulmonary bed. An early diastole flow murmur due to increased blood flow through the atrioventricular valve is noted with large defects, which originates at the mitral valve in ventricular and aortic-pulmonary shunts, and is tricuspid in origin when associated with atrial defects. The emptying time of the right ventricle and the subsequent closure of the pulmonary valve are delayed in left-to-right shunts at the atrial level which results in wide fixed splitting of the second sound. Development of increased pressure in the pulmonic circuit reduces the interval between aortic and pulmonary valve closure and accentuates the intensity of pulmonic component of the second sound. A decrescendo high pitched diastolic murmur of pulmonic incompetency results when pulmonary hypertension develops.

The pulmonary arterial trunk and branches become enlarged in these shunts, and the increased pulmonary blood flow is manifested by increased pulmonary vascularity; hyperpulsatility is noted on fluroscopy. Heart chamber enlargement and electrocardiographic changes reflect the altered hemodynamics and location of the shunt. Increased volume work of a

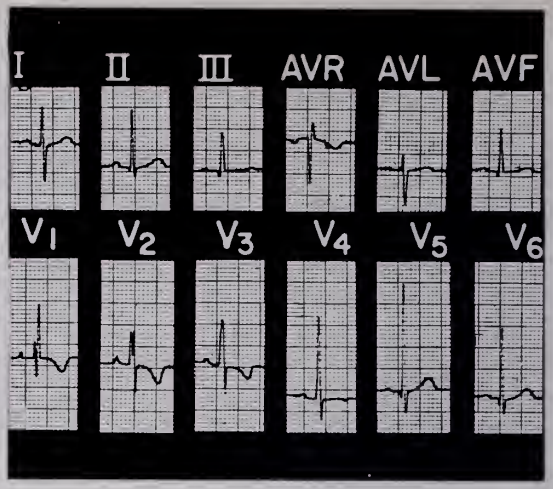


***Fig. 1. Right ventricular enlargement in a child with an atrial septal defect. Note RSR' complex in lead VI. This is an example of diastolic (volume) overloading of the right ventricle.**

**Illustration from "Outline of Electrocardiography": Friedman, H., McGraw-Hill Book Co., 1963. Used by permission of the publisher.*

ventricle (diastolic overload) is to be differentiated from increased pressure (systolic overload) work. The heart chamber receiving an increased blood volume dilates to a degree without significant hypertrophy. Diastolic overload is recorded in the electrocardiogram by RSR' complexes over the right precordial levels (delayed activation of the right ventricle designated as incomplete right bundle branch block) or by increased voltage of QRS and T potential over the left ventricle (Figures 1 and 2). Ejection of blood against an increased resistance, without an increase in stroke volume, results in myocardial hypertrophy without an increase in heart size as noted radiologically.

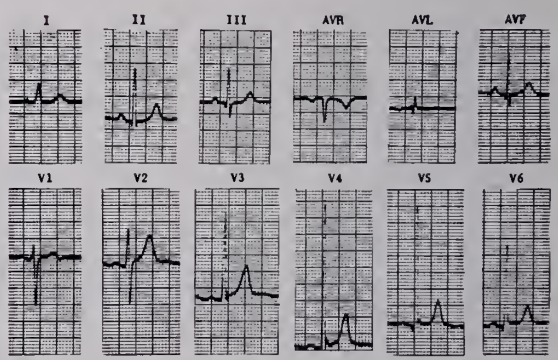


***Fig. 2. Left ventricle enlargement in a child with a ventricular septal defect. Note high voltage of R wave in lead V5. This is an example of diastolic overload of the left ventricle.**

**Illustration from "Outline of Electrocardiography": Friedman, H., McGraw-Hill Book Co., 1963. Used by permission of the publisher.*

Electrocardiographically, an increased R potential over the involved ventricle with inverted ST-T changes reflects this phenomena (Figures 3 and 4).

Low pressure left-to-right shunts at the atrial level result in volume overload of the right atrium and right ventricle and are not complicated by increased pulmonary resistance or pressure, until late in life. Small defects at the ventricular or aortic-pulmonary level do not alter the heart size or result in changes in the electrocardiogram. Large defects produce a diastolic (volume) overload of the left ventricle and varying degrees of volumetric overload of the right ventricle. With an increase in the size of the defect, the pulmonary circulation is presenting increasing amounts of blood from the left ventricle, and pulmonary hypertension develops, producing systolic (pressure) overload of the right ventricle. The volume of blood shunted depends upon the size of the defect

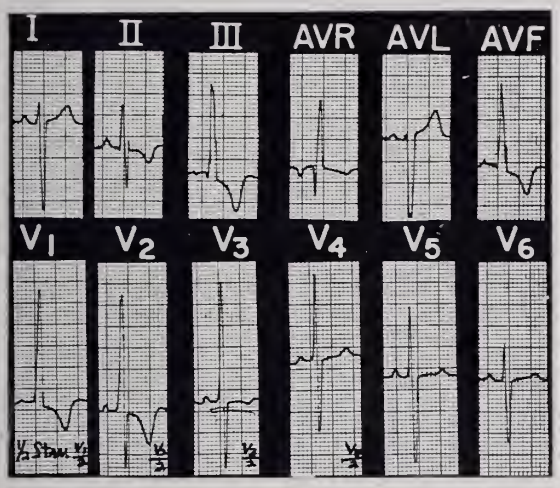


***Fig. 3. Right ventricular enlargement and strain in a child with pulmonary stenosis. Note R pattern with inverted T wave in VI through V3. This is an example of systolic (pressure) overloading of the right ventricle.**

**Illustration from "Outline of Electrocardiography": Friedman, H., McGraw-Hill Book Co., 1963. Used by permission of the publisher.*

and the pulmonary vascular resistance, which is related to pulmonary arteriolar constriction or to secondary intimal and medial arteriolar vascular thickening, proliferation, and obstruction. The degree of reversibility of the pulmonary vascular resistance is dependent upon the extent of these changes.

Visible and palpable evidence of these altered hemodynamics becomes manifested by precordial deformities, palpable ventricular overactivity, thrills and accentuated pulmo-

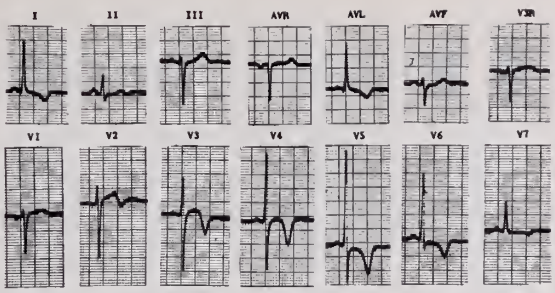


***Fig. 4. Left ventricular enlargement and "strain." Note high voltage of R wave in AVL and V5 and S-T segment and T wave changes. This is an example of systolic overloading of the large ventricle in a child with aortic stenosis.**

**Illustration from "Outline of Electrocardiography": Friedman, H., McGraw-Hill Book Co., 1963. Used by permission of the publisher.*

nary valve closure. Cardiac catheterization detects the level of the shunt by demonstrating arterialization of the venous blood at the involved chamber. Indicator-dilution curves recorded at a systemic artery following a right heart injection demonstrate a characteristic pattern proportional to the volume of pulmonary recirculation (Figure 5). An indicator introduced into the left side of the heart or distal pulmonary artery is detected prematurely in the right side of the heart at the level of the shunt, thus providing a means of localizing defects (Figure 6). Quantitation of the degree of the shunt is determined by the Fick principle or by indicator-dilution curves. Angiocardiography may be utilized in the diagnosis of this group of lesions by selective chamber injection into the left heart or aorta and visualizing the location of the shunt. Pulmonary artery pressure is related to flow and resistance and becomes elevated from large flows which result in changes in the intima and media of the small muscular arteries and arterioles. Since there is an inverse mathematical relationship between resistance and flow, it can be understood that increasing resistance acts as a limiting factor to the volume of left-to-right shunts.

In truncus arteriosus there may be a single main arterial trunk to supply the systemic, pulmonary and coronary circulations. If the pulmonary blood flow is high, cyanosis may be delayed. Diagnosis is suspected by the presence of a single second heart sound, a systolic murmur at the third left intercostal space, an apical systolic click not varying with vespirations and often a diastolic murmur along the left sternal border associated with aortic insufficiency. The lesion may be misinterpreted by angiocardio-

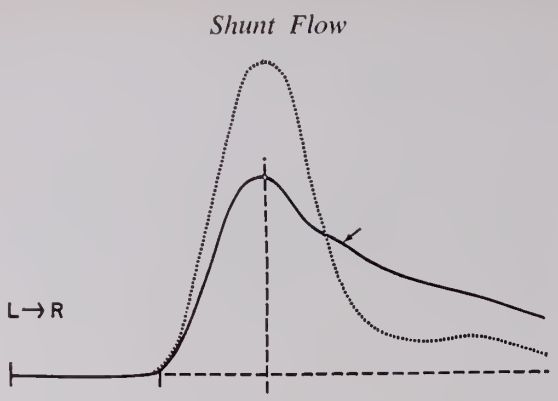


*Fig. 5. A normal curve (brokenline) is superimposed. Curve is characterized by normal appearance and build up times, reduced peak concentration, and prolonged disappearance slope. The peak concentration is reduced because of a portion of the dye is shunted from left to right and reenters the pulmonary circulation. The shunted dye after passing through the pulmonary circulation enters the left heart. One portion follows the normal path and arrives at arterial sampling site to produce the "hump" (arrow). The remaining portion enters the shunt and the cycle is repeated.

*Illustration from "A Primer of Cardiac Catheterization": Kory, Tsagaris, Bustamante, Charles C. Thomas Publishing Co., 1965. Used by permission of the publisher.

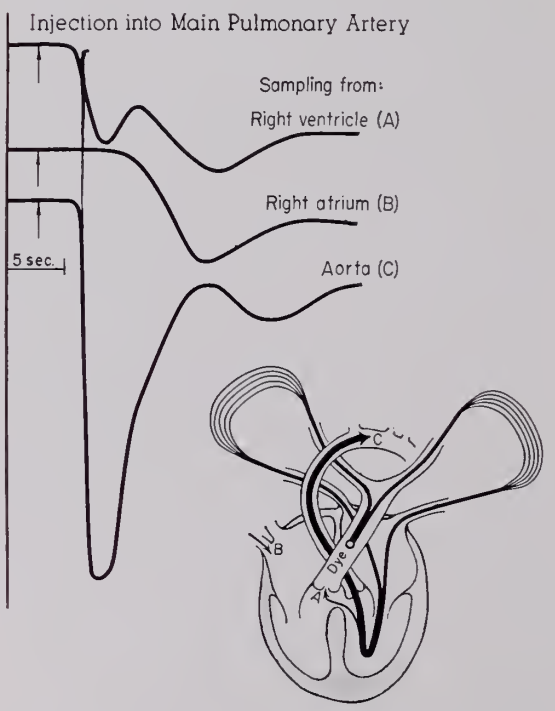


*Fig. 6. Double catheter technique for detecting small left-to-right shunts. Dye is injected into distal pulmonary artery. A sampling catheter is placed in the pulmonary trunk where first sampling is obtained, then withdrawn to right ventricle, and then right atrium where dye curves are obtained. Dye curves are shown in ventricular septal defect. Early appearance of dye in right ventricle (A), but not right atrium (B) indicating a ventricular shunt.

*Illustration from "Heart Disease in Children": Gasul, Arcilla, Lev, J. B. Lippincott Co., 1966. Used by permission of the publisher.

graphy alone for a large ventricular septal defect, or single ventricle, if the contrast injection is made into the right or left ventricle. This misinterpretation is avoided if a retrograde aortic injection is obtained.

II. *Obstructive lesions without communication between the systemic and pulmonary circuits.* These anomalies include ventricular outflow obstructions as valvular, supravalvular, subvalvular aortic stenosis or pulmonic stenosis, coarctation of the aorta or pulmonary arteries, primary pulmonary hypertension, congenital mitral stenosis, and cor triloculare.

Increased resistance to ventricular ejection force produces systolic overload of the respective ventricle resulting in hypertrophy, dilatation, and eventually failure. The heart must maintain an adequate flow and pressure in the systemic and pulmonary circuits through an orifice, which is reduced in size. A decreased cardiac output, associated with increased circulatory demands following exertion, characterizes these obstructive lesions. The demonstration of trans-valvular systolic gradients on catheterization of the right or left sides of the heart is diagnostic and a harsh crescendo-descrendo murmur ("diamond-shaped murmur") bespeaks a ventricular ejection force through an obstructed outlet. The delayed emptying time of the ventricle prolongs the closure of the respective semilunar valve and results in a delay and attenuation of the second sound concomitant with the severity of the obstruction. Blood pressure determinations of the upper and lower extremities and diminished femoral pulses point to a diagnosis of a coarctation of the aorta, and the associated development of collaterals is recognized by auscultatory bruits, palpable intercostal vessels and radiological evidence of rib notching. Aortic arch narrowing can be suspected by comparison of the blood pressure in both upper extremities and by comparison of the quality of both carotid pulses which help localize the extent and degree of obstruction. Obstruction to flow in the peripheral pulmonary arteries results in continuous murmurs heard in either axilla, depending on the major artery or peripheral branch involved.

The association of obstructive lesions in Group II with communicating lesions in Group I is not uncommon. Pulmonary outflow tract

obstruction is often associated with ventricular and atrial septal defects. A combination of mild pulmonary stenosis in the presence of systemic-pulmonary communications results in hemodynamics of Group I with a constant left-to-right shunt without cyanosis. Severe pulmonic stenosis produces a right-to-left shunt with under-saturation of peripheral arterial blood.

III. *Non-obstructive valvular and vascular lesions.* These anomalies include insufficiencies of the tricuspid (Ebstein's Anomaly), pulmonary, aortic and mitral valves. Tricuspid insufficiency is the hallmark of Ebstein's Anomaly which results in a shortened ejection time of the right ventricle and a dilated right atrium. The large tense right atrium produces a characteristic sound in a systole and diastole ("atrial scratch") and a fourth heart sound along the lower right sternal border. Other circulatory findings include an opening snap over the lower sternal area due to a fibrosed tricuspid valve and a diastolic rumble in the same area due to rigid deformity of the valve. In contradistinction to the usual soft first heart sound which characterizes mitral and tricuspid insufficiency, the first heart sound in Ebstein's Anomaly is loud and snapping due to fibrous changes in the anterior leaf of the valve. Congenital aortic regurgitation is manifested by a diastolic murmur at the left sternal border caused by a bicuspid aortic valve or a prolapsed valve cusp associated with a ventricular septal defect. Idiopathic pulmonary regurgitation is a rare lesion recognized by loud diastolic murmur at the upper left sternal border associated with no other hemodynamic abnormalities, as the effect of the pulmonary insufficiency is not serious because of the low diastolic pressure in the pulmonary artery. Congenital solitary mitral insufficiency results in the identical symptoms and signs found in rheumatic heart disease. The only significant difference from rheumatic mitral insufficiency is the presence of moderate pulmonary hypertension.

IV. *Communications between the systemic and pulmonic circuits with dominant systemic blood flow.* The combination systemic-pulmonary communications with severe obstruction to the right ventricular outflow tract produces a reversal of the normal pressure relations between the right and left ventricles, with shunting of venous blood from right to left resulting in arterial desaturation. Obstruction to right ventricular outflow tract occurs in pulmonary stenosis, or hypoplasia or atresia of the pulmonary artery. The obstruction can result from pulmonary arteriolar changes produced by pulmonary hypertension, a complication of shunt lesions in Group I. A diminished pulmonary flow, compared with the systemic flow, results. Right ventricular overload in this group is termed systolic or pressure overload. Radiologically, the lung fields reveal decreased vascularity and because of veno-arterial shunting, cyanosis is present. Reversal of flow of the ductus arteriosus produces cyanosis of the lower portion of the body. Systemic desaturation results in secondary polycythemia and vascular complications (thrombosis) due to increased viscosity of the blood. Diminution of the pulmonary blood flow results in episodes of cerebral hypoxia, convulsions, syncope and collapse.

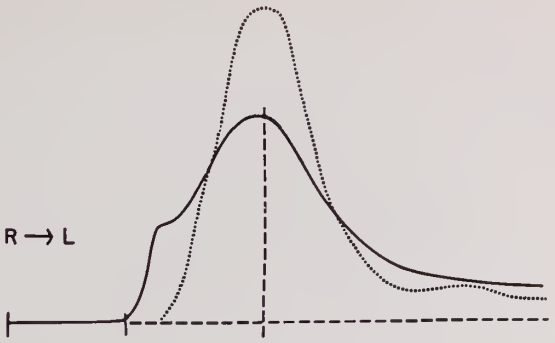


***Fig. 7. A normal dye curve is superimposed (brokenline) for comparison. Note early appearance of dye in form of "hump" on ascending limb of curve. The initial peak is due to dyed blood shunted from right to left via an abnormal communication between chambers of the right and left sides of the heart. The second peak represents dye which has traversed the normal pathways through the lungs and left heart to arrive at the arterial sampling site.**
**Illustration from "A Primer of Cardiac Catheterization": Kory, Tsagaris, Bustamante, Charles C. Thomas Publishing Co., 1965. Used by permission of the publisher.*

Catheterization of the right side of the heart detects the site and degree of obstruction of the right ventricular outflow tract. Indicator-dye dilution curves recorded in a systemic artery spot the level of the communication by the early appearance of the indicator following injection proximal to or at the level of the defect (Figure 7). Cineangiocardiograms demonstrate these communications and visualize the level of and also the anatomical configuration of the obstructive lesion.

V. *Lesions in which there is a common mixing chamber (total anomalous pulmonary venous drainage into the right atrium, single atrium, single ventricle, tricuspid atresia).* Systemic arterial oxygen unsaturation characterizes this group and the degree depends upon the ratio of pulmonary to systemic blood flow which is governed by obstructions in the respective ventricular outflow tracts, and the relation of pulmonary to systemic resistence if there is associated pulmonic stenosis. The radiological interpretation of the degree of vascularity depends upon these relationships. In the situation of increased pulmonary to systemic flow ratios, the systemic blood will be relatively highly saturated. Total anomalous pulmonary venous drainage and single atrium clinically may stimulate atrial septal defect; however, secondary pulmonary hypertension is less frequent in the latter. In the anatomical types of tricuspid atresia, all venous blood entering the right atrium meets an obstruction at the atretic tricuspid valve and is diverted to the left atrium, where complete mixing with pulmonary venous blood occurs, and thence into the left ventricle, which also serves as a common mixing chamber. Ventricular overload is related to the respective flows through the aorta and pulmonary arteries and the volume of venous return. In the case of a single ventricle and tricuspid atresia with no obstruction to pulmonary blood flow, the pulmonary arterial tree is subjected to systemic pressure.

In lesions with a common mixing chamber, bidirectional shunting occurs and in the absence of definite streaming of the blood, the pulmonary artery and systemic oxygen saturations are equal. Indicator-dilution curves with sampling from a systemic artery demonstrate division of blood flow after right heart injection at the involved chamber or, an upstream site indicative of a right to left shunt with early systemic appearance, and a demonstration of pulmonary recirculation compatible with a left-to-right shunt.

VI. *Transpositions.* The transpositions involve relationships between the aorta and pulmonary arteries. The pulmonary blood flow is usually adequate or excessive. The presence of associated defects determine the prognosis by providing varying degrees of mixing between the systemic and pulmonary circuits. This group is characterized by systemic arterial oxygen desaturation and increased pulmonary vascularity except in the case of transposition with an interventricular septal defect and pulmonic stenosis. Cineangiography, catheterization and indicator-dilution curves reveal the reversed aorta-pulmonary artery relationships and bidirectional shunting at the level of the ventricles, atria or ductus arteriosus.

Corrective Surgery

Communications between the systemic and pulmonic circuit with a significant unidirectional left-to-right shunt are amendable and will benefit by complete surgical closure which restores equality to systemic and pulmonary flow. Elevated pulmonary artery pressures usually fall following closure of the causative defect when the pulmonary blood flow, which exceeds systemic blood flow, is reduced by surgical closure. The increased pulmonary pressure usually falls when it is secondary to high blood flow. The pulmonary resistance diminishes less rapidly when microscopic arteriolar changes are present. When the pulmonary resistance is high and the pulmonary blood flow is diminished, as compared with the systemic blood flow, surgical closure of the defect is valueless, and the mortality following closure is high. Infants with large left-to-right shunts at the ventricular level may develop severe congestive heart failure. The problem is whether to attempt surgical closure in early infancy or rely on medical management until further growth is obtained, thus lessening the high mortality associated with complete closure in a small infant. The procedure of banding the pulmonary artery in such small infants is well established with the view of decreasing the pulmonary blood flow, relieving the congestive heart failure and preventing the development of high pulmonary resistance. The procedure will diminish the pulmonary blood flow, and the infant will grow, and the defect can be closed at a later age.

Combined defects as right ventricular outflow obstruction associated with septal defects are amendable to complete simultaneous correction. Total correction of septal defects and obstructions to the outflow trace carries a high mortality in infancy. The choice procedure in these infants consists of either a Blalock or

(Continued on Page 1014)

Biopsy of Neck Tumors†

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A plea is made that surgeons do a complete x-ray, laboratory and physical search for the primary cause of a neck mass before doing a biopsy and then plan their treatment to cure the patient rather than to make a diagnosis at the expense of ultimate care.

THE medical student's first lesson is salutory: Become aware of the medical history and the over-all condition of the patient before undertaking adequate handling of the problem. It seems reasonable to re-emphasize this lesson whenever biopsy of a neck tumor is being considered. The biopsy of these tumors, other than aspiration biopsy, is an important surgical procedure, not to be regarded lightly. Perhaps we have been astonishingly ignorant of our tendency to focus more attention on biopsy and less on definitive surgery.

Lesions of the Nasopharynx

The first sign of a nasopharyngeal malignancy is usually a metastatic lymph node in the neck. It is inexusable, however, to enter the lymphatic channels of the neck for purposes of diagnosing a malignancy of the nasopharynx without first having examined that area. In this area, both the examination and the biopsy can be accomplished by approaching the lesion through the nose, or, after the induction of general anesthesia, by retracting the soft palate. Aspiration biopsy is a less formable procedure and is sometimes indicated. If the primary lesion is controlled with cobalt, neck dissection with removal of the lymph nodes of the neck en bloc may save the patient's life.

Lesions Involving the Tonsil, Tongue, Mouth, Pharynx, and Larynx

In such cases, the diagnosis should be based upon results of biopsy of the primary lesion, not on the biopsy of a metastatic neck node. Whenever feasible, neck dissection with removal of primary malignant lesions should be performed immediately, en bloc with the neck nodes. Radiotherapy directed to the primary lesion and subsequent adequate surgery may also be carried out in certain cases.

Thyroid Gland Tumors

Hemi-thyroidectomy is preferred over biopsy of a lump in the thyroid. A paralyzed vocal cord, which may be noted in the laryngeal mirror, in a patient with a "lump" in the thyroid gland or in a distant lymph node of the neck should alert the physician of the possibility of a malignant tumor of the thyroid gland and/or the mediastinum. The discovery of a paralyzed vocal cord after thyroid gland surgery presents a difficult diagnostic problem if no preoperative laryngeal examination was done.

Malignant Tumors of the Submaxillary Gland

The surgical measures directed toward malignancy of the submaxillary gland are most discouraging even with the best of present-day facilities. Only one in 10 patients with squamous cell cancer is free of disease at the end of five years.[1] Cure of the patient may depend in large part on the skill of the pathologist at the time of surgery. A preoperative asperation biopsy can sometimes be helpful. It is in the best interests of the patient that a suspiciously enlarged suxmaxillary gland be completely removed whether or not the lesion has been proved malignant by frozen section. Neck dissection usually is indicated, as a primary procedure, if frozen section proves the presence of a malignancy. The survival rate for patients with this deceivingly malignant disease could be increased with adequate primary surgery. Biopsy of a primary lesion of the submaxillary gland is indicated only when

†*Presented at the Meeting of the Northern Kentucky Cancer Clinic, Booth Hospital, April 28, 1967*

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definitive surgery obviously is impossible and there is need for the establishment of both the grade and the type of malignancy for purposes of x-ray therapy for medicolegal purposes.

Investigating the Parotid Gland Tumor

Biopsy of parotid gland tumors is fraught with danger to the patient's face and to the surgeon's reputation as to his diagnostic ability and surgical skill.[2] Facial paralysis has resulted from biopsy of the parotid gland while the malignant lesion, lying beneath the superficial lobe of the parotid gland and the facial nerve, had not been reached. Definitive treatment, therefore, was delayed. Biopsy, other than asperation biopsy, of the parotid gland is nearly always contraindicated. The correct technic is as follows:

1. Identify the facial nerve lying beneath the tympanomastoid fissure at the stylomastoid foramen.
2. Perform total superficial lobectomy, making sure to preserve the facial nerve.
3. Following superficial lobectomy, it is possible to retract the facial nerve and remove the deep lobe when indicated.

Should the question be raised, however, as to whether or not one should sacrifice the facial nerve, frozen section is obtained and further treatment is based upon the pathologist's report. Neck dissection may or may not be indicated.

Lesions of the Lung, Stomach, Sinuses and Other Distant Areas

Endoscopic studies, x-rays and blood studies are frequently indicated before a lesion of the neck is biopsied.

The chest, sinuses and digestive system can all be the location of a primary malignancy which may manifest itself first by a metastatic neck node. The lung is so frequently the source of supraclavicular metastatic cancer that it deserves special emphasis.

Complications

The biopsy of the neck mass can produce complications. Facial paralysis can occur; when it does, it is difficult to excuse the surgeon. A case has recently come to my attention where hemiplegia resulted from biopsy of a carotid body tumor. The spinal accessory, the hypoglossal and the vagus nerves have all been injured; hemorrhage, infection and death (although rare) have also been known to result from biopsy of neck lesions. Therefore, only after every other effort to find the primary lesion has been made should biopsy of the involved area be made. Even then the surgeon ought to be prepared to proceed definitively with whatever pathology he may encounter.

Summary

A plea is made that surgeons do a complete x-ray, laboratory and physical search for the primary cause of a neck mass before doing a biopsy: and then plan their treatment to cure the patient rather than to make a diagnosis at the expense of ultimate care.

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Arterial Injuries in Civilian Practice

David A. Hull, M.D., F.A.C.S.,* and Gordon L. Hyde, M.D.**

Lexington, Kentucky

Acute arterial injuries seen in private practice are usually associated with other severe injuries and are caused by vehicular accidents. Eighty-seven per cent limb salvage can be expected and this may be improved with prompt recognition and vascular reconstruction.

THE aims of treatment of an arterial injury continue to be control of primary hemorrhage, prevention of secondary hemorrhage and preservation of the limb. During the second World War, when ligation was the primary form of treatment, the amputation rate was approximately 49 per cent,[1] which certainly reveals the inadequacy of this form of therapy. The primary treatment has thus changed to the point that the previously accepted concept of saving life by ligation or amputation in major vascular injuries can no longer be held as adequate therapy, and an attempt to restore normal flow is now mandatory. During the Korean War, Spencer and Greene and others urged immediate vascular reconstruction, and the amputation rates fell to 11 to 13 per cent.[2,3,4] Morris and Patton have extended this experience into civilian practice and have reported increasingly better results.[5,6] It is felt that this has been due to the shorter interval in which the primary therapy could be instituted and to the fact that civilian injuries resulted in less destruction of tissue and less severe types of injury. However, their reports primarily revealed the etiology of the injuries to be acts of aggression, resulting in sharp penetrating injuries or gun shot wounds in large metropolitan areas.

The purpose of this report is to evaluate our experience with 31 consecutive patients with various acute arterial injuries seen in civilian private practice. The majority of these wounds were the result of vehicular accidents and produced severe arterial injuries which were associated with extensive soft tissue and bony injuries.

Diagnosis

The diagnosis of an arterial injury can be made with ease if the artery is exposed and bleeding at the time initially seen. Pulsatile external bleeding is frequently absent and a subfascial hematoma develops. A hematoma in the tissues, continuing bleeding from the wound and distal vascular changes manifested by absent distal pulses, coolness of the extremity, anethesia and paralysis confirm the existence of an arterial wound. Most authorities agree that spasm of a major artery, although occurring in arterial injuries, is seldom severe enough to be significant, and sympathetic blocks have only confused the issue when employed to differentiate spasm from an organic block. Therefore, employment of sympathetic blocks results in unwarranted delay in the institution of primary treatment.

Factors Influencing Prognosis of Arterial Injuries

Major arterial wounds repaired within a nine hour period resulted in no amputations in the Korean War, where those repaired after nine hours incurred an amputation rate of 25 per cent.[7] If, however, the time interval between injury and treatment is delayed, reconstructive attempts should not be withheld, since amputation is the only recourse. It naturally follows that the longer the time lag, the less favorable the prognosis and the more certain it is that the distal extremity, after reconstruction of its arterial supply, will develop ischemic changes and necessitate fasciotomy in the immediate post-operative period. The liberal use of fasciotomy is advisable and employed frequently, even to the point of anticipating its need. Large, soft tissue wounds em-

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barrass collateral circulation and if the arterial injury is present, or suspected, it emphasizes the need for immediate arterial repair.

Location of the wound influences prognosis in that the amputation rate is much higher in wounds of the lower extremity than those of the upper. Listed from the most to the least critical, they are as follows: The common femoral artery, popliteal artery, combination of anterior and posterior tibial arteries, brachial artery (above the deep brachial) superficial femoral artery, common iliac artery, axillary artery, brachial artery (below the deep brachial).[7]

Patients seen in a hypovolemic state have reduced perfusion in the wounded extremity distal to the major arterial wound, and thrombosis and tissue ischemia will often occur if the patient is in profound shock, which is often present with multiple associated injuries. The more extensive local wound damage and greater delay of institution of operative therapy, because of mis-diagnosis or necessity for resusicitative measures and definitive procedures for other wounds, affect the prognosis adversely.

The type of arterial injury also is important. Traumatic arterial spasm carries with it a good prognosis, whereas complete severance and loss of substance yield less favorable results. Whenever the ends of the severed vessels can be anastomosed, prospects for success are better than when a graft is necessary. However, extensive injuries frequently necessitate use of a prosthesis, and when indicated, autogenous saphenous vein graft is preferable. Soft tissue coverage is mandatory after successful arterial repair. Failure to surround the repaired artery with muscle, fascia, subcutaneous tissue, etc., may be followed by disruption of the exposed artery, particularly at the suture line. Development of infection in a wound, particularly in a vascular repair, is disastrous. Aggressive treatment by re-debridement, local installation of anti-biotics, flap transposition plus massive systemic anti-biotic treatment frequently will prevent disruption or thrombosis.

TABLE 1
ACUTE ARTERIAL INJURIES
Etiology

Automobile and Motorcycle Accidents	17
Gun Shot	5
Knife or Sharp Penetrating Wound	5
Iatrogenic Wounds	4

TABLE 2
ACUTE ARTERIAL INJURIES
Location of Injuries

Subclavian + Axillary	5
Brachial	9
Radial + Ulnar	4
Femoral + Popliteal	9
Ant. + Post. tibial	2
Carotid	2

Review of Patients

The etiology of injuries in our series of 31 cases is shown in Table 1. Seventeen of the injuries were primarily deceleration injuries from automobile or motorcycle accidents, this being in direct contrast to the reported military series. These patients generally had multiple associated injuries which compounded the treatment. Only one-third of the injuries were typical gun shot or sharp penetrating wounds, as seen in military practice and previously reported in civilian practice.

Iatrogenic, or physician induced wounds, occurred in four patients as a result of arteriographic studies. The first of these was a result of retrograde catheterization through the femoral artery with local thrombosis. Endarterectomy of the common femoral artery resulted in restitution of arterial flow.

The second case developed brachial artery thrombosis as a result of sub-intimal injection of dye into the brachial artery. Three operative procedures, with eventual reversed autogenous vein graft, resulted in restoration of distal pulses and limb salvage. The third case was similar to the first described, resulting from retrograde femoral studies and underwent endarterectomy with equally good results.

The fourth iatrogenic wound was a result of a percutaneous carotid puncture. This patient immediately underwent endarterectomy of the carotid artery following recognition of the injury. Prior to carotid arteriography the patient was hemiparetic. The subintimal injection was recognized immediately and endarterectomy, using a shunt, was performed. The success of this repair was demonstrated 24 hours later by a repeat arteriogram.

The location of injuries is illustrated in Table 2. The upper extremity was predominately involved with the subclavian axillary artery in five patients, the brachial artery in nine and the radial and ulnar arteries in four. The lower extremity was involved in only one-third of the patients with the femoral popliteal system

in nine of these 11 patients, the anterior and posterior tibial arteries being involved in the other two. The carotid artery was involved in two patients. The frequency of associated fracture and nerve damage with the arterial injuries in this series is rather significant in that all the subclavian and axillary arterial injuries was associated with severe brachial plexus involvement and neurologic deficits. (Table 3) Of the brachial artery injuries, three had associated fractures and of the nine

TABLE 3
ACUTE ARTERIAL INJURIES
Frequency of Fracture or Nerve Injury

	TOTAL	Fracture or Dislocation	Nerve Damage
Subclavian Axillary	5	2	5
Brachial	9	3	
Femoral + Popliteal	9	6	
Radial and Ulnar	4	2	2

femoral popliteal injuries, six had associated fractures. This represents two-thirds of the patients with femoral popliteal injuries, having associated fractures or dislocated joints which greatly influence their prognosis. One patient had complete transection of the forearm and underwent re-implantation.

The type of treatment is outlined in Table 4. All patients had initial resuscitation, and shock was controlled by pressure tourniquets or clamping to control bleeding. As soon as the diagnosis was established, the patient was taken to the operating room and appropriate vessels were exposed in order to get adequate control of the bleeding. At this point, debridement of the vessel was carried out and if adjacent vein was concomitantly involved, this was first repaired, and with the use of Heparin and Fogarty catheters to remove thrombii and obtain good back flow, the vessel was reconstructed by whatever method was appropriate. At the conclusion of the arterial repair, arteriography was frequently carried out to establish the patency of anastomosis, as well as that of the distal arteries.

Ligation was carried out in one patient with a lacerated post-tibial artery. Prior to ligation, however, patency of the anterior tibial artery was established by arteriography, a policy which is advocated before any arterial ligation. Reversed autogenous vein graft was used in 17 patients, indicating the severity and the magnitude of the local vascular wound. Debridement of the injured vessel frequently necessitates the use of vein grafts to obtain satisfactory blood flow. However, to illustrate the more limited type of arterial injury, end to end anastomosis was performed in seven patients. These injuries were all of the sharp penetrating variety. The vessel ends were retracted somewhat but could easily be brought into apposition without tension. A vein patch was used in two patients in which a lateral arterial tear was present and endarterectomy with patch in two patients. The use of reversed autogenous veins in all patients where grafts are necessary is recommended and the use of an artificial prosthesis is to be avoided when at all feasible.

TABLE 4
ACUTE ARTERIAL INJURY
Type of Treatment

Ligation	1
Vein Graft	17
End to End	7
Vein Patch	4
Endarterectomy + Patch	2

The failure of arterial reconstruction resulting in amputation is illustrated in Table 5.

TABLE 5
ACUTE ARTERIAL INJURIES
Amputation — Cause

1. Venous Thrombosis
2. Shock + Multiple Injuries-Arterial repair terminated.
3. Inadequate Bone Fixation.
4. Clostridium Welchii Infection

There were four amputations of the total 31 cases, or 13 per cent. Brief analysis of them illustrates the problems inherent in the treatment of vascular injuries.

The first patient had a femoral artery and vein injury secondary to his leg being caught in a concrete mixer. This resulted in an 18 hour delay in diagnosis and institution of treatment before vascular reconstruction was accomplished. In addition to the delay of operative intervention, this patient had a massive venous thrombosis. Despite venous thrombectomy, venous end to end repair and arterial re-anastomosis, massive gangrene developed. At amputation the artery was demonstrated to be patent.

The second failure had a femoral artery repair which was felt to be inadequate but because of multiple severe associated injuries, efforts to restore flow were abandoned and he underwent mid-thigh amputation five days later.

The third case was a 13 year old boy initially seen with a fractured left femur and an ischem-

ic leg. At surgery, a completely transected femoral artery was repaired by end to end anastomosis. Skeletal traction was instituted. On the seventh post-operative day, the patient was taken back to the operating room for casting of his fracture. During the transportation and manipulation which were necessary for casting, his arterial anastomosis thrombosed. This was not recognized, presumably because of the cast, until the following day and mid-thigh amputation was the result. Despite the presence of contamination and opinions to the contrary, internal fixation in patients with associated fractures and vascular anastomosis is mandatory.

The fourth patient was seen with a severe brachial arterial injury associated with a fracture dislocation of the elbow and maceration of tissue. This injury was secondary to a car "side swipe" accident. Internal fixation of his fracture, extensive debridement of soft tissue and reversed autogenous vein graft bridging the arterial defect were to no avail. He developed a clostridium welchii infection and required amputation at mid-arm level for gas gangrene.

Conclusion

1. Experience with 31 cases of acute arterial injuries in civilian practice is presented.

2. The etiology, pathology and factors affecting prognosis of acute arterial injuries in civilian practice have been reviewed, stressing the frequency and severity of automobile and motorcycle accidents.

3. The accepted dictum, gained from the Korean War, is that arterial reconstruction is mandatory, reserving arterial ligation for only those cases which have been shown to have adequate circulation by means of arteriography or those cases in which it is necessary as a life-saving procedure.

4. The most frequent causes of failure in cases of acute arterial injury are

a) delay in diagnosis or institution of treatment

b) inadequate skeletal fixation of associated fractures

c) infection.

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SPECIAL ARTICLES

The Potential Impact Of The Kentucky Educational Television Network On The Health Sciences

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AND
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WITHIN a year, the new Kentucky Educational Television Network should be in operation. The Network will give an unprecedented boost to health science communication within this state. It seems appropriate, therefore, that the health professions be made aware of the potential of this Network and the possibilities for its use in disseminating health science knowledge to the professions and to the public. It is important that the professions begin planning soon for the best possible use of this excellent new facility.

The Kentucky Authority for Educational Television has been in existence for some years and has spent much effort in research and planning for the projected television network. This planning culminated last fall in the grant of $2,000,000 from two federal agencies, the Educational Television Facilities Branch and the Appalachian Regional Commission. This $2,000,000 grant will be supplemented by the sale of $7,500,000 in bonds which will make a grand total of $9,500,000 for the initial Educational Television Network. Network headquarters will be in Lexington and a $1,250,000 facility is being constructed on the University of Kentucky campus, close to the present football practice field. (Figure 1) This building will contain two production studios and offices and technical equipment necessary for the Network Center. The Kentucky Educational Television Network will be the most comprehensive educational television system to exist in any state. The initial system will consist of two components: open circuit and closed circuit. (Figure 2)

Open Circuit System: This will consist of 12 broadcasting stations located throughout Kentucky. From these 12 stations it will be possible for programs to be received by any UHF television set in the state and in contiguous areas of several other states. The 12 stations can either operate as one unit transmitting the same program, or they can be operated in regional groups. Transmitters will be located in Murray, Madisonville, Bowling Green, Elizabethtown, Owenton, Hazard, Morehead, Pikeville, Somerset, Madison County, Ashland and Covington.

Closed Circuit System: This will consist of microwave links between all public, two and four year, higher educational institutions. These are: four-year colleges, University of Kentucky, Eastern Kentucky University, Murray State University, Morehead State University, Western Kentucky University and Kentucky State College. The two-year institutions which will eventually be part of the system are: Cumberland, Hazard, Prestonsburg, Ashland, Somerset, Fort Knox, Covington, Bowling Green, Hopkinsville, Henderson and Elizabethtown. In most cases, this will be a one-way link with programs possible outward from the Network Center at Lexington to these locations. However, from Morehead, Richmond, Frankfort, Louisville, Bowling Green, Lexington (U.K.) and Murray, two-way communication by television will be possible. The colleges will be able to use this system without charge. Production centers for the origination of programs will be at Louisville, Richmond, Morehead, Frankfort, Lexington, Murray and Bowling Green. There will be two production centers in Lexington, the University of Kentucky studio and the Network Center. It will, of course, be possible to expand both the open circuit and the closed circuit systems to meet any future needs which might arise in the state.

Opportunities for the Health Sciences

IMMEDIATE

On activation of the Network, it will be possible to begin immediately with programs designed to:

a. Provide continuing education for the health professions

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FIGURE 1. The Network Production Center of the Kentucky Authority for Educational Television will be located on Cooper Drive in Lexington and will house the studios, administrative offices and central distribution system of the Network.

b. Educate the public
c. Inform the health professions
d. Improve science education
e. Aid Health Science Education with other, less direct, applications.

CONTINUING EDUCATION

Several possibilities exist in this area.

1. Using the closed circuit system, groups could gather in any of the two and four year colleges which will be connected in the system and could watch programs coming over the closed circuit system. The programs could be followed by a question and answer period in some instances either using the two-way capability of the Network, or by telephone lines. The disadvantage of this approach would be that the members of the profession involved would have to leave their homes and gather in a central meeting place at a particular time each week or month, whenever the group meets. The next possibility would eliminate this disadvantage.

2. Home viewing over open circuit television. Continuing education programs could be broadcast over the open circuit system, but because of the demands on the Network, this would probably have to be at relatively inconvenient times and might not meet the demands of the professions. Some of the disadvantages of this system would be that: (a) Any member of the public could also watch the program. (b) The participant could miss a program because of another commitment, and (c) He would not be able to watch the program over and over so as to become thoroughly familiar with its contents. The third possibility would eliminate these last two disadvantages.

3. Continuing education by home video tape recorder. Recent improvements in the capabilities and price of home video tape recorders make it a realistic possibility that this instrument can be used for continuing education of the professions. It would be possible for professional groups to get a quantity discount on a home video tape recorder with a built in timer switch. The participants in a continuing education course could then either watch the program as it was first transmitted and record the program at this time, or set their timer switch so that the program could be recorded in their absence. After this, the tape could become part of the individual's library where it could be reviewed at any time in the future and as many times as necessary. When necessary, the tape could be erased and reused. This meets the three cardinal requirements of a good continuing education program which are place, time and pace. The continuing education course can thus be studied at the most convenient place for the participant, that is, his own home. It can be studied at the most convenient time for him because it is solely his choice when he does it. It can be done at the most convenient pace for the individual because he can repeat or review the material at his own personal speed.

EDUCATION OF THE PUBLIC

Programs can be broadcast over the open circuit system to reach various groups in the state. For example, a daytime program in hygiene could be directed to varying age groups in the school population. This could supplement and illustrate the classes already being given in schools throughout Kentucky. A similar application would be the programming of adult directed programs during the late afternoon or evening hours; for example, in nutritional advice for housewives or information on family planning. Further possibilities exist in stimulating increased participation in cancer checkups or in cervical smear programs.

INFORMING HEALTH PROFESSIONS

A program of local and general news, of interest to all health professionals, could be developed. This would keep each of the health professions informed of new developments in its field, of news of interest to health professions in Kentucky, and of opportunities available for continuing education in their profession. This would require the development of a news gathering service based in Kentucky which could gather information of interest in the state and also attend selected national meetings to obtain information of interest to Kentuckians in the health professions.

(Continued on Page 985)



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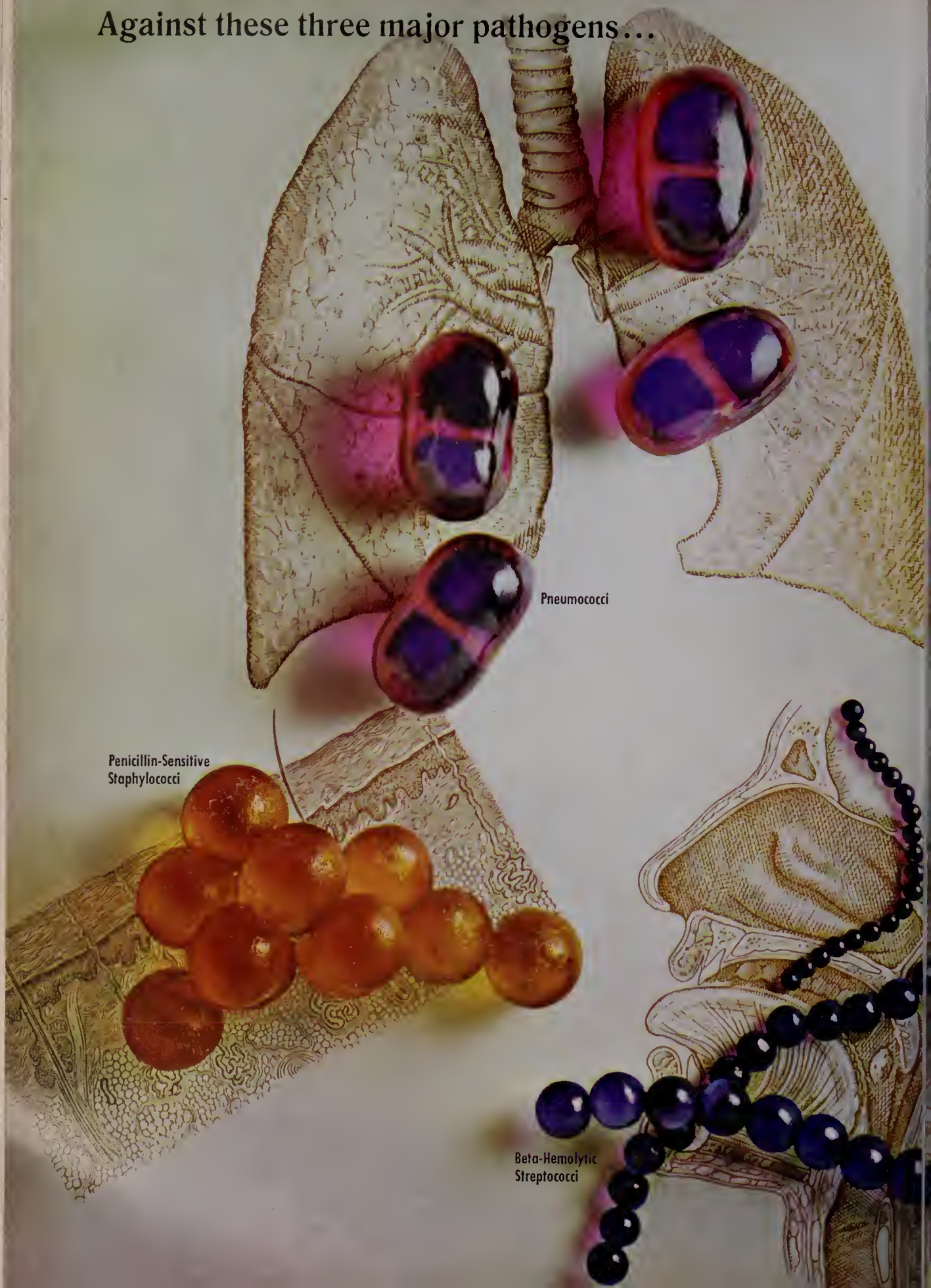
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Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at oll, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stu (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowt pencillin-insensitive organisms. In such cases, its administration sh be discontinued, and appropriate measures should be taken.

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Penicillin is a substance of low toxicity, but it does possess a sig cant index of sensitization. The following hypersensitivity reac associated with the use of penicillin have been reported: skin ra ranging from maculopapular eruptions to exfoliative dermatitis; caria; and reactions resembling serum sickness, including chills, f edema, arthralgia, and prostration. Severe and often fatal anaphy has occurred (see Warnings). Hemolytic anemia, leukopenia, th bocytopenia, and nephropathy are rarely observed side-effects are usually associated with high parenteral dosage.

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In staphylococcus infections, 400,000 units or more should be every six to eight hours in conjunction with indicated surgical p dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hou three doses may be employed; in females, 500 mg. every four h for six doses are recommended. Refractory infections generally res to a second treatment three to four days following completion o first. Treatment of gonorrhea with severe complications shoul individualized, with prolonged and intensive treatment. Patients w suspected lesion of syphilis should have a dark-field examinatio fore receiving penicillin and monthly serologic tests for a minimu three months.

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(Continued from Page 980)

IMPROVING HEALTH SCIENCE EDUCATION

Using the state ETV Network, it will be possible to strengthen courses in nursing and the allied health sciences in the community colleges and in other locations remote from the medical schools. A reduced staff at the remote location can be supplemented by experts in particular fields transmitted to the school over the closed circuit system from a central facility such as the University of Kentucky Medical Center in Lexington or the University of Louisville Medical School in Louisville. In this way, local training can be given to local people who will tend to remain in their home area and not be attracted to a larger center by having to move there for a period of years and finding the inertia of returning to their original home too great to surmount. It will also be possible for preliminary courses for the health professions to be offered nearer the home of the students involved and thus reduce the expense of an education in the health sciences. The possibility also exists of increased cooperation between medical centers which would strengthen the teaching in the participating institutions. Research would also be possible in the socio-medical area. For example, base-line studies of the public's knowledge on particular health problems could be made in two similar areas served by a different ETV station. Then educational programs could be given in one of the areas and the other used as a control to measure the effect of health education by television. There are numerous other possibilities in this area.

Other Less Direct Applications of the Network to Health Science Education

1. Student recruitment. The health sciences are having an increasing problem in attracting high caliber students to their programs. It should be possible to make the opportunities available in the health professions more widely known throughout the state and the necessary qualifications more widely understood than is possible by existing methods of student recruitment.

2. Science education in high schools. There is a severe shortage of well trained science teachers in our high schools. This affects the knowledge of incoming students at the universities and provides a continuing deficiency. Initially, science programs broadcast to the schools will benefit the students but, as time goes on, the effect of these programs on the high school faculty will be even more advantageous. For example, the teachers will see examples of good teaching in the sciences and begin to apply them to their own classes directly rather than indirectly by television. Academic knowledge of the sciences in the high school faculties will improve and the indirect education of faculty by television may well make the need for science education by television less necessary than it now is.

3. Improving teachers in high schools. As described in the previous paragraph, the beneficial effects on teaching in the sciences will be spread throughout the high school and grade school curriculum, not only because of the direct effect of a program beamed to the students but also the possibility of instituting continuing education for school teachers by television into each individual school, thus making it easier for teachers to upgrade their qualifications without leaving home to attend a university. In the same way, programs in the community colleges can be improved and, thus, students will come to the main university with a greater knowledge and exposure to education than has been true in the past.

4. Combating illiteracy. It will be possible for the television network to institute programs in adult education to improve reading and writing skills in the less educated members of the population who did not

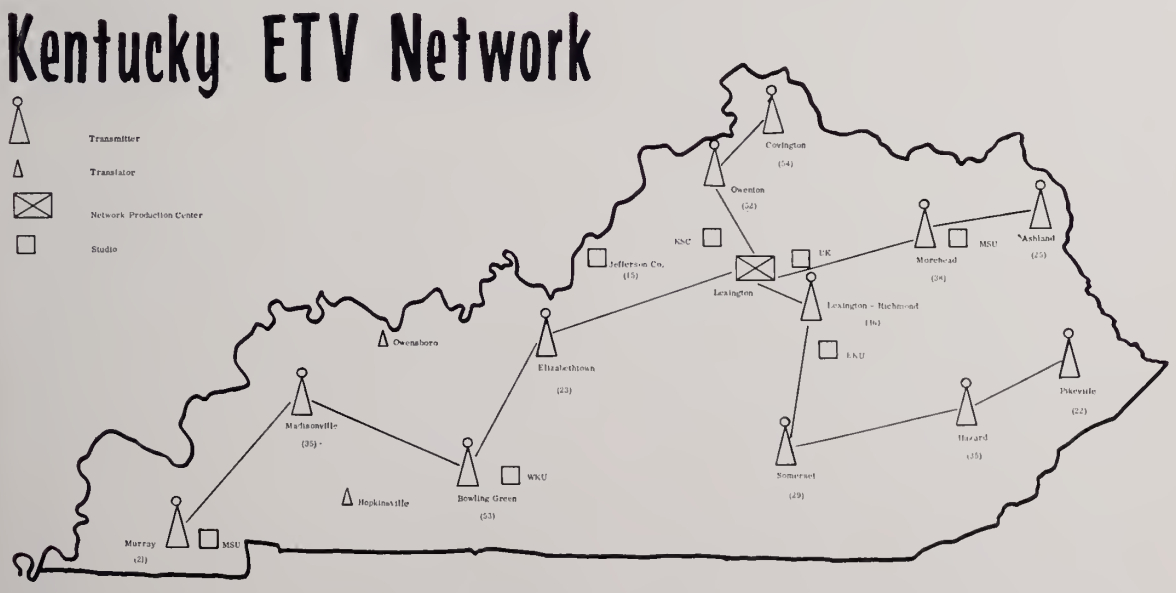


FIGURE 2. This diagrammatic map of the state shows the 12 transmitters and the channels they will use, the Network Production Center, the seven associated studios, and the two translators. The connections are also shown. The Network may be expanded in the future if necessary.

benefit from long continued or adequate schooling. In this way it may be possible to improve reading skills so that patients can better understand instructions and gain health information by reading and thus become more cooperative and knowledgeable patients.

5. A better educated population. As well as the improvement in reading skills, referred to in the previous paragraph, a better educated population better able to understand the demands of good health can only be of benefit to the professions in their effort to improve the health of the population of Kentucky.

6. Civil Defense. It will be possible to have programs which will increase knowledge of the demands of a Civil Defense emergency on the population and thus the people could be better prepared for such an eventuality.

7. Vocational training for the handicapped. It will be possible to institute programs which will educate the handicapped in their homes so that they can become more productive members of the society and better able to support themselves.

8. Rehabilitation programs to remote locations. It will be possible to send programs which would help in the physical rehabilitation of patients injured or incapacitated through illness and more quickly enable them to resume a useful role in society. This would obviate the necessity of their traveling to central locations for this rehabilitation.

9. Physical education in the schools. A real need at this time is good physical education teachers in our schools. It may well be possible to teach physical education by television and thus improve the physical well being of our children through regular exercise directed by an expert.

10. Stimulation of community action. It will be possible to use the Network as a stimulating agent to persuade the population of an area to vote for and support needed community improvements, such as sewage treatment plants, recreational areas, improved water supply, flood control and other similar activities.

The preceding section describes some of the immediate possibilities which will be available as soon as the Network is activated in the summer of 1968. However, it should be pointed out that this system is by no means final and many other possibilities exist for its extension in the future.

For example: (a.) All hospitals in the state could be connected by two-way television communication and, in this way, consultations could be held with specialists in major centers. The teaching programs of the medical centers could be enriched by the transmission of unusual cases by television to the students. Radiographs could be transmitted from the smallest hospital for diagnosis by an expert radiologist. Histological sections made during an operation could be transmitted to a medical center for diagnosis by an expert pathologist, thus reducing the time necessary which can sometimes be of vital importance. Advice could be given to one surgeon by another surgeon more familiar with the condition almost as if the remotely located expert was looking over the shoulder of the man actually performing the surgery.

Another possibility, at a later date, is (b.) the use of an extended network as a means of access to a central computer which could assist, for example, in the diagnosis of cardiac conditions by analysis of electrocardiograms, could improve access to patient records which would be centrally stored on computer tape and could aid hospitals in inventory applications.

What Is Needed Now

All the possibilities enumerated in which the health professions can take advantage of this new resource in the state will only come if they are grasped energetically and preparations made for this event which is in the very near future. Each professional organization, each university teaching in the health science areas, the State Health Department, and other interested groups must work now toward the utilization of the Network when it comes into being. It seems apparent that an individual or small committee in each of these groups should be charged with the responsibility of investigating the possibilities and developing the programs for use on the Network. Although the expense of using the Network is low, some funds will be necessary for this and also for producing programs, and plans should be made to ensure that these funds are available. It will also be necessary to develop people with the necessary skills to make them able to communicate health science information by television and in a language and at a level which can be understood by the audience for whom the program is intended. Since time goes by so quickly, planning should be undertaken as soon as possible so that this excellent opportunity will not slip by.

Conclusion

The Kentucky State Educational System, which will be in operation in less than 12 months, has been described. Some of the ways health professions could use this facility to improve their professional knowledge and to improve the health intelligence quotient of the population and to improve the health care available to the people of Kentucky have been enumerated. Finally, some of the next steps in using the Network have been outlined.



Chiropractic in Kentucky

AT THE request of the Committee on Cults, the Board of Trustees has authorized the publication of this editorial which is designed to acquaint you with the cult of chiropractic as it exists in Kentucky today.

There are now approximately 400 chiropractors in active practice in the Commonwealth. They are distributed in almost equal population ratio throughout the state, except for western Kentucky where they are found in increased numbers, and in eastern Kentucky where their numbers are somewhat less. According to the Kentucky Board of Chiropractic Examiners, over one-half of the chiropractors have had no academic training beyond high school. Only 16 percent of chiropractors in active practice, according to the same source, have had two or more years of college. Two hundred forty-five chiropractors in the state are registered with the Department of Health, Radiology Division, and apparently use X-ray machines in their active practice. According to figures published in the *International Review of Chiropractic,* Kentucky led the nation in 1962 and 1963 in the number of new licenses issued, accounting for 339 out of a total of 1,331 chiropractors licensed in that two-year period. Tennessee licensed eight in the same period. Information for 1964 and 1965 is not available.

Although Kentucky chiropractors are licensed (under a 1928 state statute sponsored by Sen. John Sherman Cooper) to practice only the so-called "*science* of locating and adjusting the subluxations of the articulations of the human spine and its adjacent tissues," they treat all human ills (except cancer) on the theory that they result from nerve interference caused by a subluxation. Were it not for the Anti Cancer Quackery bill sponsored by KMA and enacted by the 1960 General Assembly, some of them might conceivably be treating cancer, since they have widely advertised the susceptibility of polio, tuberculosis, appendicitis, peritonitis, diabetes, epilepsy and high and low blood pressure to chiropractic adjustment. The are not authorized to practice surgery or obstetrics and may not dispense drugs, but may sign death certificates!

Chiropractors are active in the political arena. A chiropractor sits in the Kentucky Senate and one or more will probably be elected in November to the House. This will give them a distinct advantage in what is certain to be a renewed effort to pass bills which would (1) authorize chiropractors to make *medical* examinations and reports under the workmen's compensation law and require employers to pay for chiropractic treatment thereunder; (2) require all insurers to recognize chiropractic as a "*medical* service" under their policies; (3) authorize chiropractors to certify teacher illnesses; and (4) require payment for chiropractic treatments under Medicare.

It will also make it more difficult for us to "plug the holes" in the Anti Professional Advertising Act which was enacted in 1966. That act prohibits solicitation of patients through advertising but exempts the "circulation of educational materials which are not laudatory of the author or any person with whom he is associated in the practice of his profession, and which contain no solicitation of patients for the author of | or | any such associate of the author, which has been approved as to content by the appropriate licensing agency." Most chiropractic ads now bear the signature of the Kentucky Chiropractic Association or the notation: "Chiropractic Educational Material presented in the interest of Public Health." At least one chiropractor appears on a weekly television show allegedly sponsored by an out-of-town chiropractic educational founda-

tion, in which he shows which spinal nerve, if pinched, will cause this or that disease.

There has been for many years a law (KRS 434.270) prohibiting false and misleading advertising designed to deceive or mislead anyone into employing the services of the person advertising such services, the penalty being a fine of not more than $500 or imprisonment for not more than 60 days, or both. This statute covers handbills and direct mail solicitation as well as newspaper, radio and television advertisements and has been effective in stopping some of the most flagrant violators. Any physician who sees or hears an advertisement which appears to violate this statute should consult his county or commonwealth's attorney.

Prohibiting chiropractic advertising of course offers no real solution to the basic problem. If chiropractic is a cult devoid of scientific foundation beyond its possible value as physical therapy, then Kentucky should quit licensing chiropractors and let those who would practice physical therapy seek licensure from the State Board of Physical Therapy. Or, if a chiropractor wishes to hold himself out as qualified to diagnose and treat virtually all human ills, he should be required to know as much about the human body as a medical doctor and to demonstrate his proficiency by taking the same examination as is administered to medical doctors.

The state of Louisiana has been upheld by the United States Supreme Court in its requirement that chiropractors take and pass the same examination as that required of M.D.'s, if they are going to undertake to treat virtually all human ills. The state of Kentucky could do the same thing if physicians were more active in local politics.

Is it worth the effort to push for some real controls on chiropractic? Some physicians apparently think not, taking the position that people who go to chiropractors deserve what they get. But this overlooks the obligation of men of science to protect the public from quackery, especially when the delay occasioned by cultist treatment may be fatal.

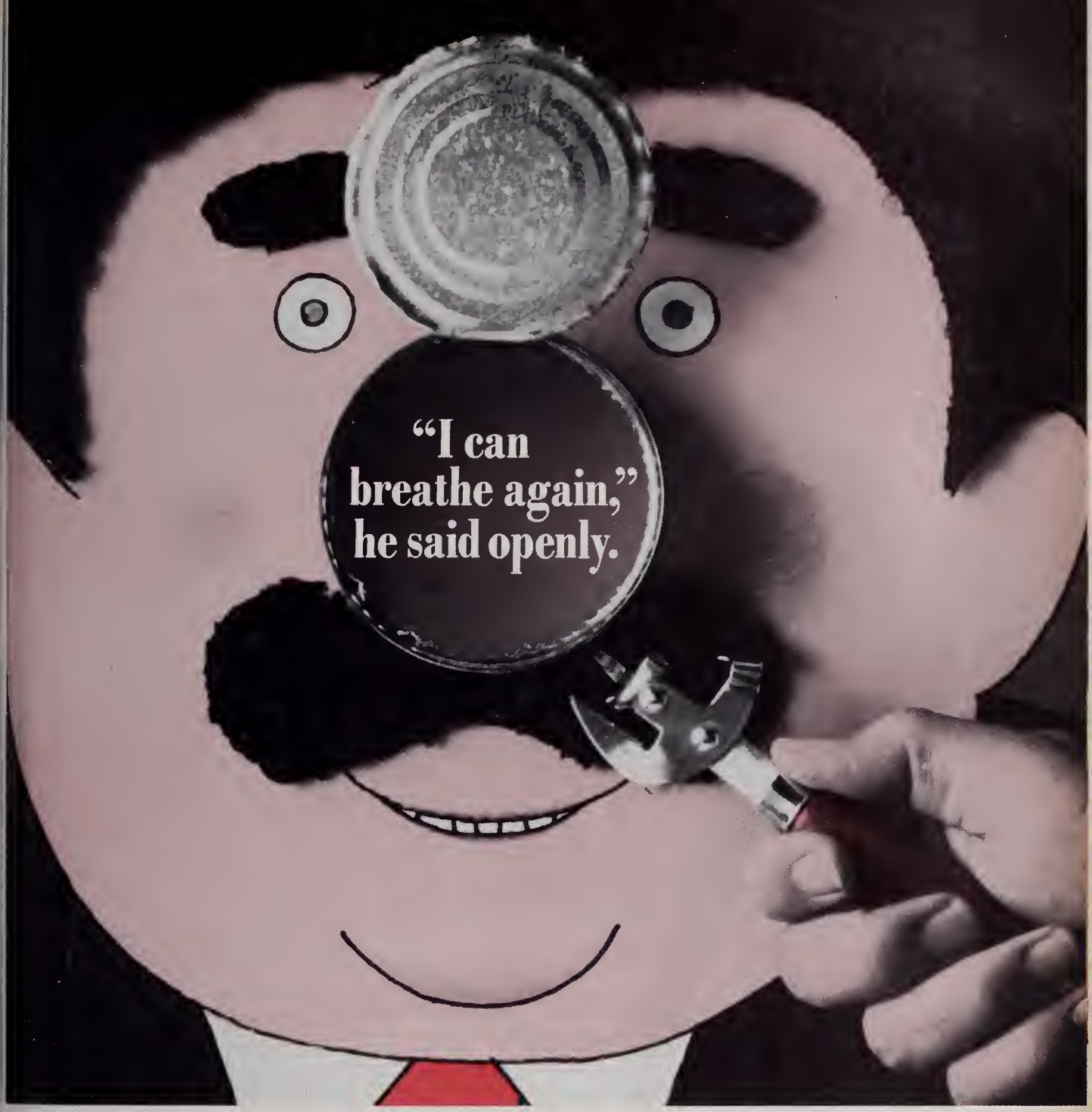
The dangers of delay were a major factor in the decision of the Federal Court upholding the Louisiana law requiring chiropractors to take the same examination as that required of physicians. The chiropractors are split into two groups: (1) the "straights" (represented by the International Chiropractic Association) who profess to believe that chiropractic manipulation will cure anything, and (2) the "mixers" (represented by the American Chiropractic Association) who believe that manipulation can cure *almost* everything *if* begun in time. The Court held that it would not be irrational or unreasonable for the Louisiana Legislature to conclude that a foundation in *materia medica* and surgery "would assist chiropractors in diagnosing disease and determining in specific cases whether or not the disease was too far advanced for successful chiropractic ministrations."

Most, if not all chiropractic advances have been political, not scientific, because as Justice Gerard Lecroix, special commissioner of the Quebec Legislature found, after an eight month investigation last year of chiropractic and its claims:

> "The idea originated by chiropractors either through ignorance or by design that manipulation is a universal remedy for all ills must be rejected unreservedly."

Kentucky's physicians will have the opportunity to aid in the prevention of the spread of this cult during the 1968 General Assembly. Every KMA member should take time *now* to establish rapport with his senator and representative. Study the AMA's newest pamphlet, "Chiropractic: the Unscientific Cult" and leave a copy with him. Copies are available at the Headquarters Office for a small charge.

E. Gaines Davis, Jr.
KMA General Counsel



in sinusitis, colds, U. R. I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. Its key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. **Dosage:** 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

A. H. ROBINS COMPANY, Richmond, Virginia 23220

A·H·ROBINS

Preludin® phenmetrazine hydrochloride



For complete details,
please see full
Prescribing Information.

helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



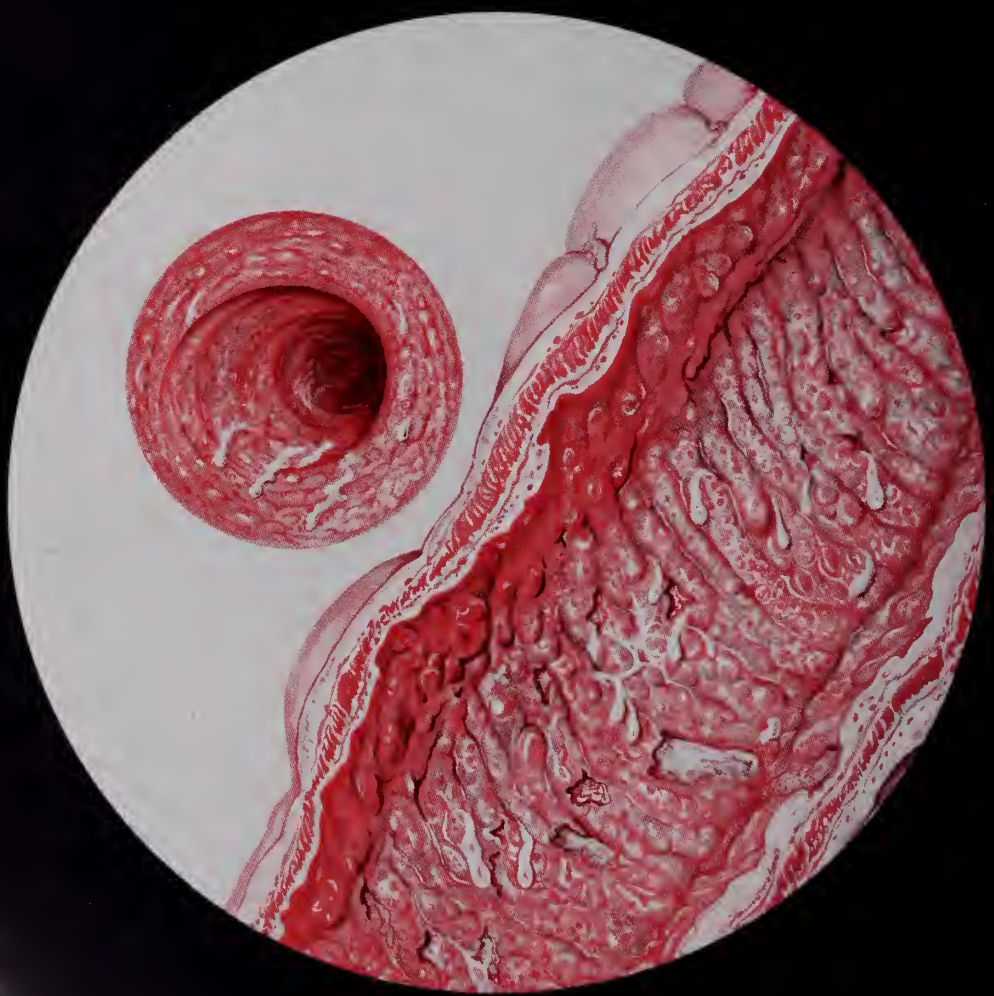
Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Under license from
Boehringer Ingelheim G.m.b.H.

even in ulcerative colitis...

characterized by:
—diarrhea, cramps, tenesmus
—bloody, mucoid, purulent stools



LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

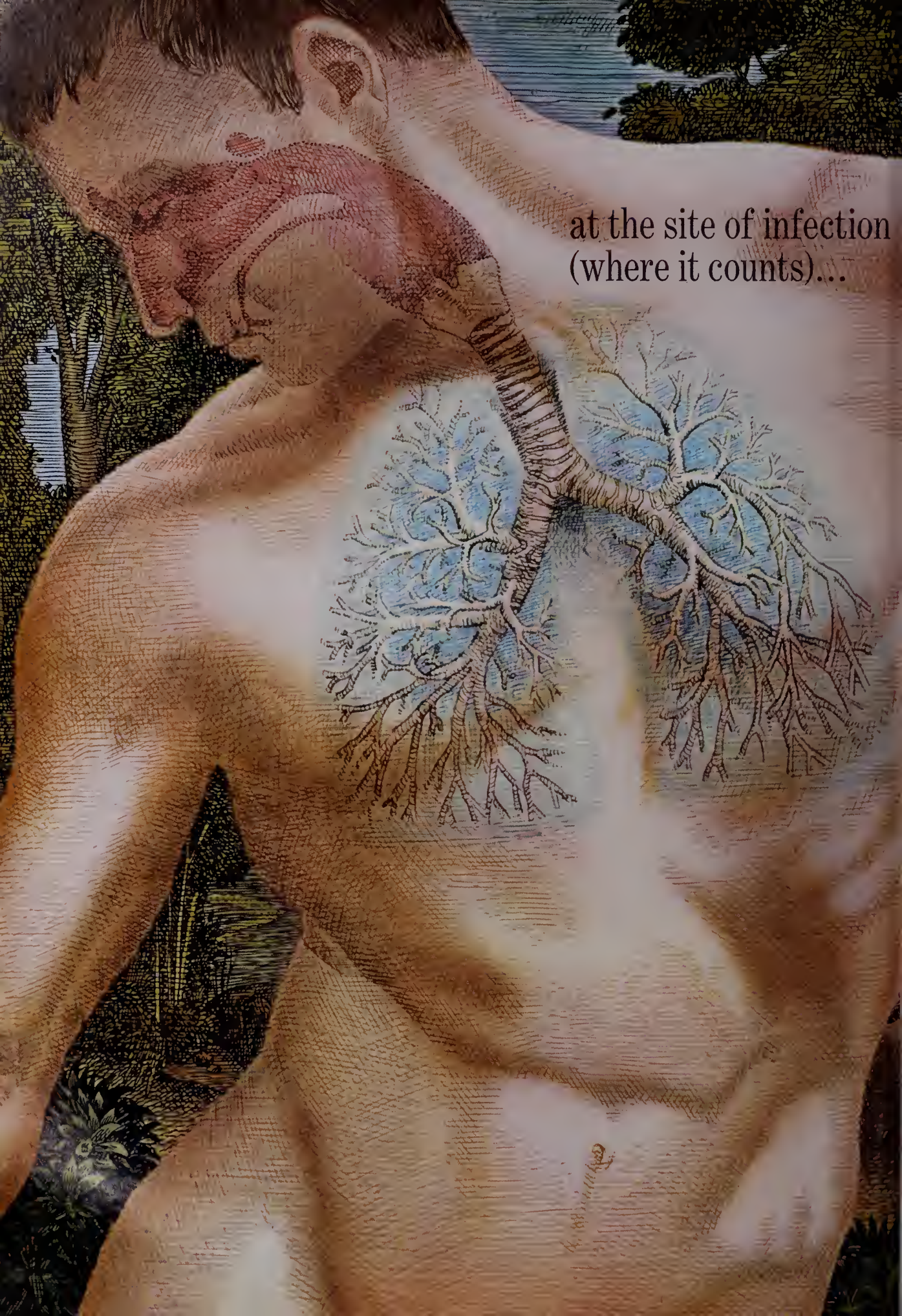
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)....

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appear be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses c medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six months patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had epi of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mont rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Elev of SGPT and serum alkaline phosphatase levels during the c of treatment was observed in one patient treated with Il and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the pen group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients comparable to those in a similar control group who had rec penicillin.

Gastro-intestinal disturbances not associated with hepat fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hour children twenty-five to fifty pounds, 125 mg. every six (Tablets Ilosone Chewable should be chewed or crushe swallowed with water.)

For adults and for children over fifty pounds, the usual d of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythro therapy should be considered.

In the treatment of syphilis, the recommended total dos 20 to 30 Gm. given in divided doses for a period of ten to days. Close follow-up of the patient is necessary since er mycin drugs have not had adequate evaluation in all sta syphilis. Examinations of spinal fluid are recommended a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four da recommended. In the treatment of gonorrhea, patients v suspected lesion of syphilis should have a dark-field exami before receiving antibiotics, and monthly serologic tests s be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25 m (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pack

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pack

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to b in bottles of 50. [0

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398,
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

ORGANIZATION SECTION

Dr. Smith Named Scientific Editor Of KMA Journal

Charles C. Smith, Jr., M.D., a Louisville internist, recently succeeded Sam A. Overstreet, M.D., Louisville, as scientific editor of The Journal of KMA. Doctor Overstreet, former editor and present associate editor of The Journal, had been serving as scientific editor on a temporary basis since the death of Jack L. Chumley, M.D., Louisville, in March of this year.



Doctor Smith

Doctor Smith graduated from the University of Louisville School of Medicine in 1955 and completed his internship at the University Hospital in Birmingham, Alabama. He served in the U.S. Air Force from 1956 to 1958 and then took his residency training in internal medicine in University of Louisville Hospitals from 1958 to 1961.

A former member of the teaching staff of the University of Louisville School of Medicine, Doctor Smith has been in private practice in Louisville since 1962.

Letter Outlines Procedure For OCHAMPUS Program

Late in the 89th Congress, the program for providing medical care to the dependents of active members of the Armed Forces which was known as "ODMC" was greatly implemented. Among other things, the program provided for usual and customary fees.

Since the passage of this legislation, the KMA Committee on Governmental Medical Contracts has been negotiating with the new agency which is known as the Office for the Civilian Health and Medical Program of the Uniformed Services. The following communication has been received from Brigadier General Norman E. Peatfield, executive director of the program which is now known as "OCHAMPUS", relating to the new procedure in implementing this program.

"Effective 1 October 1967, the Office for the Civilian Health and Medical Program of the Uniformed Services has adopted for the payment of physicians in Kentucky, a customary and reasonable fee concept similar to that of Medicare (S.S.A. Amendments of 1965). As a point of interest, in determining the reasonable charges for services, the fiscal administrator is required to take into consideration the customary charges for similar services generally made by physicians as well as the prevailing charges in the locality for similar services. The Kentucky Physicians Mutual (Blue Shield) . . . . will continue to pay physicians under this new concept."

Dr. Rouse Invites Physicians To AMA Clinical Convention

"It is with great pleasure that I invite you to my home state this fall, to the AMA Clinical Convention at Houston, November 26-29," said Milford O. Rouse, M.D., president of the AMA, in a statement urging all physicians to attend the annual event.

A scientific program designed especially for the practicing physician has been planned to include discussions of 18 major medical topics, four postgraduate courses, breakfast roundtable conferences, closed-circuit television, motion pictures and scientific exhibits. The convention will be held in Astro Hall.

Other events scheduled at the time of the convention include a meeting of the House of Delegates and the Ninth National Conference on the Medical Aspects of Sports. "It promises to be a stimulating four days, worthy of your time," Doctor Rouse said.

Ky. Chap., ACP Meets Sept. 16

Thomas M. Durant, M.D., Philadelphia, a past president of the American College of Physicians, was the featured speaker at a September 16 meeting at Stouffer's Inn, Louisville. Doctor Durant's topic was "Angina Pectoris, Then and Now."

A number of internists from the University of Louisville and University of Kentucky medical schools also participated in the program, acording to Ellis A. Fuller, M.D., Louisville, program committee chairman. Carl Fortune, M.D., Lexington, is governor of the Chapter.

KMA Annual Meeting News

Since the October issue of The Journal went to press before the 1967 Annual Meeting took place, it was not possible to include a report on that event. The November issue will carry complete coverage of the meeting and the December issue will include a digest of the proceedings of the House of Delegates meetings.

Carnation research and development laboratories
announce the first optimum-nutrition infant formula

Optimil



This extended formula, completely compatible with the infant, has demonstrated its advantages over older modified-milk formulas in intensive clinical tests.[1-4]

It provides:

OPTIMUM CONTENTMENT.
New Optimil's marked superiority in achieving satiety–reflected by infants' infrequent crying—is most reassuring to mothers.

OPTIMUM DIGESTIBILITY.
New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

OPTIMUM GROWTH.
New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Optimil is recommended as regular feeding for optimum growth and development of normal newborns; as an ideal supplement to or replacement for breast milk; as sound nutrition for prematures; and as prophylaxis against both essential fatty acid and nutritional iron deficiency.

Optimil, diluted 1 to 1 with water, provides a standard feeding formula—20 calories per oz. Supplied in new, convenient 16-oz. cans, Optimil is available for your specification at leading drug stores.



The complete Optimil system available to hospitals includes: 5% Glucose Water in presterilized 4-oz. disposable bottles • Optimil 13 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil 20 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil Concentrated Infant Formula in 16-oz. cans • Sterilized disposable nipples • Optimil Gift Pack: six 4-oz. disposable bottles of Optimil 20 calories/oz. Prepared Formula* and one 16-oz. can of Optimil Concentrated Infant Formula.

**prediluted and sterilized*

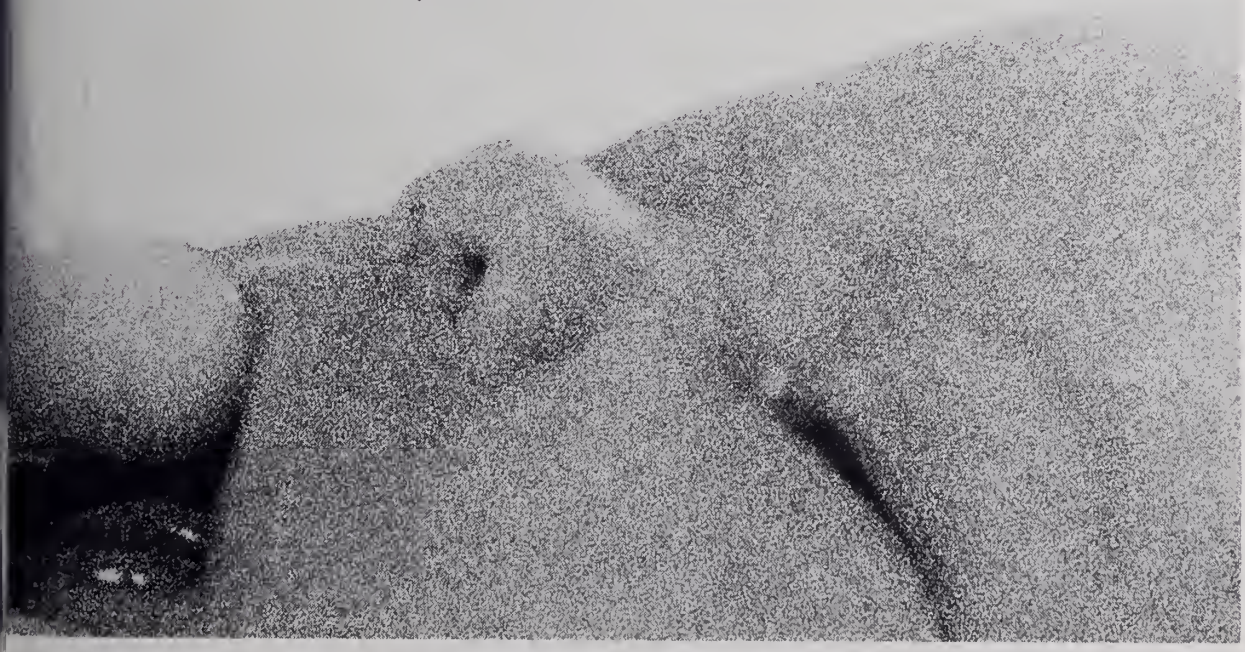
1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

Watch for further details on Optimil, the first optimum-nutrition infant formula

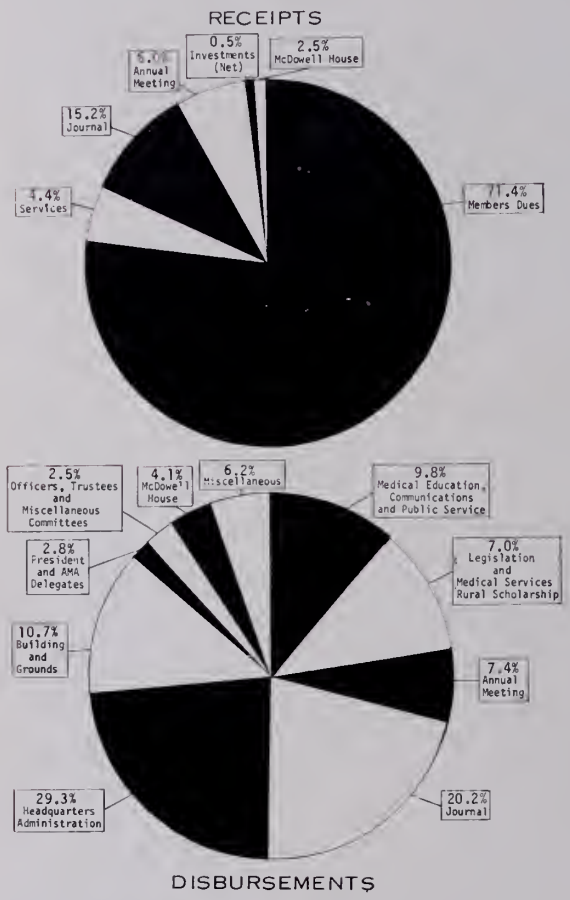
from a world leader in nutrition— Carnation ®

CARNATION COMPANY / 5045 WILSHIRE BOULEVARD / LOS ANGELES, CALIFORNIA 90036



Graphs Show Distribution Of Association Funds

The pie-shaped graphs shown below demonstrate the sources of KMA income and the distribution of these funds. The figures were prepared by the Association's auditors and are based on the 1966-67 fiscal year. The Headquarters office will welcome any questions from members concerning the information depicted by the graphs.



AMA Not Among "Top Spenders" For Lobbying Activities

According to the *Congressional Quarterly,* the American Medical Association is not included in the 24 "top spenders" of the 296 organizations which filed lobby reports with the federal government. In 1966 the AMA spent $49,000 for lobbying activities.

Heading the top 24 group is the United Federation of Postal Clerks (AFL-CIO) with $287,000; the Brotherhood of Locomotive Firemen and Enginemen, Grand Lodge (AFL-CIO) $199,000; and AFL-CIO (National Headquarters) $169,000.

In 1965 the AMA did spend $1.1 million. This was the year when it barely lost the Medicare fight in the House of Representatives. In all other years, according to the *Congressional Quarterly,* the AMA was not to be found among the leaders.

While the lineup of front runners changes from year to year, labor organizations are always to be found among the leaders, with the total spent by organized labor often dwarfing the expenditures of other groups.

An AP story carried by the Chicago Tribune on March 19, 1967, reporting on a little publicized phase of U.S. operations, the government lobby, stated that the federal government expends about $425 million a year on its "public information, news, views, and self-pleadings." The story continued that "much of the expenditure, which has risen steadily through successive National Administrations, is devoted to convincing Americans (with their own money) that what the government does is for their welfare."

Mr. McConnell Attends Washington Health Insurance Conference

J. Ed McConnell, president of Kentucky Physicians Mutual, Inc. (Blue Shield), was one of 50 participants scheduled to attend the National Conference on Private Health Insurance September 28 and 29 in Washington, D.C.

Those attending the conference, which was held to further develop the matters discussed at a June 27-28 conference in Medical Care Prices, represented the medical profession, health insurance industry and hospitals.

Panel chairmen included Donald Stubbs, M.D., former chairman of the board of directors of the National Association of Blue Shield Plans, J. Douglas Colman, president of Associated Hospital Services in New York, and J. Henry Smith, president of the Equitable Life Assurance Society of the United States.

Ky. Thoracic Society Schedules November Meeting at Berea

A fall conference on respiratory diseases has been scheduled by the Kentucky Thoracic Society for November 17 and 18 at Boone Tavern Hotel, Berea, according to Hugh S. Fulmer, M.D., president.

Topic listed on the program for the meeting include "The Epidemiology of Chronic Non-Specific Respiratory Disease," "Clinical Problems in Blastomycosis" and "Tuberculosis and Its Control."

A series of case presentations scheduled for the Saturday afternoon session will include "Bronchiectasis in Children," "Diagnosis of Systemic Fungus Infections" and "Broeck's Sarcoid."

(See page 1008 for program details)

Three Join Hospital Staff

Three Middlesboro physicians were recently appointed to the staff of the Appalachian Regional Hospital by the Board of Trustees, according to a published report. They are F. Sheldon Downs, M.D., a general practitioner, William P. Grover, M.D., a surgeon, and Kenneth W. Moss, M.D., a pediatrician. All are associated with the Daniel Boone Clinic.

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

**a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics**



A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Talwin 30 mg. relieves pain usually as quickly and effectively as morphine 10 mg.*

whatever the intensity of the pain

whatever the cause of the pain

whatever the site† of the pain

whatever the chronicity of the pain

whatever the age†† of the patient

without the liability of narcotics

without the development of tolerance on prolonged use

with less risk of severe respiratory depression than with morphine

with less constipation

with less urinary retention

Clinical experience of more than 150 investigato with over 12,000 patients given varying dosages Talwin shows that this potent injectable analges is not a narcotic.

Talwin has less risk of severe respiratory depre sion, urinary retention, and constipation than mo phine—a great boon for postsurgical patients.

Talwin produces less nausea, vomiting and di phoresis than meperidine.

Constipation and urinary retention are seldom problem with Talwin.

Very rarely do hallucinations or disorientation c cur (0.1% each).

No significant hepatic, renal, hematopoietic or ne rologic disturbances have been reported.

Talwin is well tolerated even by the aged or very patients.

Used during active labor, its tolerance by t mother and newborn is comparable to mepe dine's. As with all new drugs, Talwin should be us with caution in pregnant women and in women c livering premature infants.

Tolerance to the analgesic effect of Talwin has n developed with prolonged use.

Talwin gives significant relief of pain in from 15 20 minutes following I.M. or S.C. injection.

Talwin relieves pain usually for 3 hours or longe with a single injection; however, the duration m sometimes be less than with morphine.

*Its duration of action may sometimes be less than that of morphine.

†Should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

††Until sufficient experience is gained, Talwin should not be administered to children under 12 years of age.

86 per cent of medical and surgical patients obtained excellent to good relief with Talwin 30 mg. administered parenterally

Talwin
brand of pentazocine (as lactate)

used for pain of all types

Talwin has a wide range of usefulness in surgery

Types of surgical use	Number of patients	Efficacy				
		% Exc.	% Good	Exc. + Good	% Fair	% Poor
• Preoperative	118	31	52	83%	15	2
• Postoperative	914	58	28	86%	8	6
• Pre- and postoperative	12	75	17	92%	0	8
• Minor surgery	33	30	39	69%	0	31
• Traumatic	14	64	29	93%	7	0
• Dental	33	67	24	91%	3	6
Total patients.....1124						

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of surgical use in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

High incidence of poor results in minor surgery is due primarily to one study involving change of burn dressings in children; 9 of 19 patients obtained poor results with dose used.

Talwin relieves all types of pain in acute and chronic medical disorders

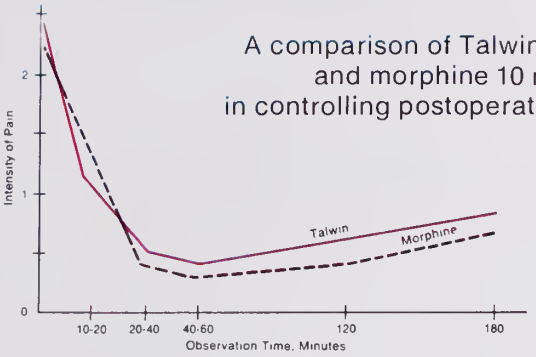
Type of medical pain	Number of patients	Percentage of relief				
		Excellent	Good	Exc. + Good	Fair	Poor
• Malignancy, pain in	161	44	37	81%	8	11
• Orthopedic; see also "Arthritis"	111	53	38	91%	5	4
• Cardiovascular pain; see also "Miscellaneous medical"	96	59	27	86%	6	7
• Genitourinary pain	83	42	33	75%	16	10
• Arthritis	76	33	51	84%	12	4
• Gynecologic pain	35	57	34	91%	6	3
• Cephalalgia	21	45	41	86%	9	5
• Gastrointestinal pain	19	89	5	94%	0	5
• Chest, including • Pleurisy • Pulmonary embolism and infarct • Lung abscess	12	83	17	100%	0	0
• Miscellaneous medical, including • Peripheral vascular disease • Thrombophlebitis • Cervical root pain • Facial neuralgia • Syringomyelia • Burns	108	50	39	89%	9	2
Total patients.....722						

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of medical pain in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

See next page for additional product information

Talwin relieves pain as quickly as morphine



A comparison of Talwin 30 mg. and morphine 10 mg. I.M. in controlling postoperative pain*

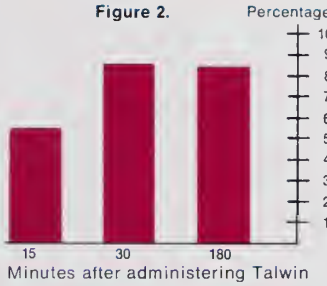
Figure 1.

Talwin 30 mg. proved equivalent to morphine 10 mg. in overall analgesic efficacy. During the early post-medication period (up to 40 minutes after drug injection), Talwin was superior in effect to morphine.

After observation periods ranging from 40 to 180 minutes there was no difference between the drugs in their effect on intensity. There were 141 and 119 complete patient records for Talwin and morphine, respectively, in this double-blind study. Other clinical investigators, studying duration, state that relief with Talwin may be obtained for up to three hours or longer, a period sometimes less than morphine's.

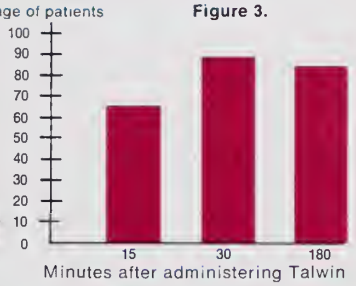
Talwin is as effective for severe pain (Fig. 2) as for moderate pain (Fig. 3)

Figure 2.



Per cent excellent to good relief of severe pain obtained with 30 mg. Talwin in 218 postoperative patients

Figure 3.



Per cent excellent to good relief of moderate pain obtained with 30 mg. Talwin in 203 postoperative patients

Talwin does not require a narcotics prescription or narcotics records

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally."‖

*Storer, E. H. Data in the files of the Sterling-Winthrop Research Institute.

†Cooperative study, data in the files of the Department of Medical Research, Winthrop Laboratories.

‖*World Health Organization Technical Report Series*, No. 343, 1966, p. 6

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. **Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. **Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

PRINTED IN U.S.A. ISSUED AUGUST, 1967 (1035M)

HEW Publishes Pamphlet Outlining Medicaid

According to Francis L. Land, M.D., Commissioner of Social and Rehabilitation Service of HEW, a new pamphlet has been developed entitled "What's Medicaid to an M.D."

Doctor Land says, "We think the pamphlet will give you a brief, readable explanation of the Medicaid program and the physician's part in it. We will be glad to send you additional copies, if you will let us know how many you can use."

Please contact the KMA Headquarters office if you would like copies of the pamphlet.

KMA Adds 23 Physicians To Its Membership

The Kentucky Medical Association has 23 new members according to the records of the membership department as of September 20.

New members in Lexington are Arthur E. Butterfield, M.D., Harold T. Faulconer, M.D., Hart James, M.D., Joan K. Mattingly, M.D., John M. Stoeckinger, M.D., Hugh A. Storrow, M.D., Charles E. Vanetti, M.D., William G. Wheeler, Jr., M.D., and Jonathan D. Wirtschafter, M.D.

New members in Louisville include Peter Campbell, M.D., Carolyn R. McKelvey, M.D., Louis Kahle, M.D., David Ringel, M.D., and Walter H. Zukof, M.D.

Other new members are Paul B. Barton, M.D., Corbin; Leonard S. Berman, M.D., Maysville; Harry O. DeBandi, M.D., Madisonville; Ronald F. Howard, M.D., Cadiz; Leslie E. Karr, M.D., Corbin; William T. Moore, M.D., Glasgow; Luigi Pacini, M.D., Pleasure Ridge Park; Jim Rogers, M.D., Madisonville; and James C. Seabury, M.D., Paducah.

Blue Shield Report Shows Records In Enrollment, Benefits Paid

The number of people served and medical-surgical benefits paid by Blue Shield in 1966 reached record highs, according to the annual report published by the National Association of Blue Shield Plans for its 84 member Plans.

Blue Shield served more than 71 million persons, more than one-third of the population, and paid out $1.4 billion in benefits during 1966, a figure up $52 million from the previous year.

The 33 Blue Shield Plans serving as carriers for 60 per cent, some 10 million, of the aged under Title XVIII Part B are doing well in spite of the obstacles that had to be overcome, according to Carl R. Ackerman, M.D., NABSP board chairman. Title XIX programs in more than 10 states are administered by Blue Shield today and other Plans have applied for Title XIX roles.

Blue Shield and Blue Cross coverage of individuals under the Federal Employee Program increased from 56.1 to 57.1 per cent during 1966, according to John W. Castellucci NABSP president.

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In Memoriam

ERNEST W. AKINS, M.D.
Louisville
1899-1967

Ernest W. Akins, M.D., 68, a retired general surgeon, died September 12 at Kentucky Baptist Hospital. Doctor Akins graduated from the University of Louisville School of Medicine in 1922. Before his retirement in 1965 he was chief of staff for the regional Veterans Administration office of medical services. He had been with the VA for 20 years.

J. RANDOLPH BUSKIRK, M.D.
Louisville
1900-1967

J. Randolph Buskirk, M.D., 67, a Louisville physician for 40 years, died August 28 in Cincinnati. Doctor Buskirk graduated from the University of Louisville School of Medicine in 1928. He was a member of the World Medical Society, Southern Medical Association and the Kentucky Academy of General Practice. Doctor Buskirk was a veteran of World War I.

OLIVER H. PARRIGIN, M.D.
Monticello
1890-1967

Oliver H. Parrigian, M.D., 77, a retired physician, died August 14 at his home. Doctor Parrigin graduated from The University of Louisville School of Medicine in 1916 and after serving in the Army Medical Corps during World War I opened his office in Monticello in 1919. He retired in 1951 because of ill health.

RICHARD C. PORTER, M.D.
Louisville
1912-1967

Richard C. Porter, M.D., 55, a general practitioner and surgeon, died September 1 while being taken to St. Anthony Hospital. Death was attributed to a heart attack. Doctor Porter graduated from the University of Louisville School of Medicine in 1936 and had been in practice in Louisville for 29 years. He was a veteran of World War II and a member of the staff at St. Anthony Hospital.

Infections Control Conf. Planned

"Infections Control in Hospitals", a conference sponsored in part by the Kentucky Medical Association, has been planned October 11 and 12 at the University of Louisville's Bigelow Hall, according to G. Dudley Nelson, M.D., one of the program chairmen.

Local and national speakers will discuss the various aspects of the topic during the two-day conference. Complete programs have been mailed to KMA members.

Mr. McConnell on NABSP Committee

J. Ed McConnell, president of Kentucky Physicians Mutual, Inc. (Blue Shield), was recently appointed a member of the Study and Planning Committee for the National Association of Blue Shield Plans. The committee will study ways to improve the voluntary prepayment system of insurance.

KMA Council and Committee Reports

Governmental Medical Contracts Committee

L. Douglas Atherton, M.D., Louisville, Chairman

KMA Headquarters Office **August 16, 1967**

The Governmental Medical Contracts Committee met with Colonel Robert H. Holzworth, M.D., of OCHAMPUS and representatives of Blue Shield to discuss the new contract under the CHAMPUS program, which will call for usual and customary fee payment to physicians effective October 1, 1967.

The program concept used by Title XVIII of the Social Security Administration will be the formula used for all new CHAMPUS contracts.

Advisory Committee on Title XVIII

Paul J. Parks, M.D., Bowling Green, Chairman

KMA Headquarters Office **September 6, 1967**

The Advisory Committee on Title XVIII met with three Vice Presidents of the Metropolitan Life Insurance Company to discuss mutual problems relative to the fiscal agent for Part B of Title XVIII of Public Law 89-97. The Metropolitan officials present were:

Paul I. Robinson, M.D., vice president and chief medical director

William S. Thomas, vice president, group division

LaRue S. Wagenseller, vice president, group insurance

There was considerable discussion relative to possible courses of action which Metropolitan could take to additionally strengthen the relationship between the Kentucky physicians and Metropolitan Life Insurance Company.

Dr. Bosomworth To Head Program

Peter P. Bosomworth, M.D., professor and chairman of the department of anesthesiology at the University of Kentucky Medical Center, has been named director of a new training program for clinical anesthesiology made possible by a five-year grant which the University received recently.

The primary objectives of the new program are to increase the number of physicians in anesthesiology and to improve the quality of their training.



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Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

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100s, 500s, 5000s

Solfoton Capsules *(yellow and brown)*
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Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

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DOCTOR

For a rewarding learning experience in relaxed surroundings

KENTUCKY THORACIC SOCIETY CONFERENCE ON RESPIRATORY DISEASES

November 17 and 18

Boone Tavern Hotel—Berea, Kentucky

FRIDAY, NOVEMBER 17

5:30 p.m. "Get Acquainted" Social Hour

6:30 p.m. Dinner
Hugh S. Fulmer, M.D., Presiding
"Tuberculosis Eradication Project in Haiti"
H. Mac Vandiviere, M.D., Lexington

SATURDAY, NOVEMBER 18

9:00 a.m. "Tuberculosis and Its Control"
Kenneth S. Welsh, M.D.

9:40 a.m. "The Epidemiology of Chronic Non-Specific Respiratory Disease"
Hugh S. Fulmer, M.D., Lexington

10:30 a.m. "Clinical Problems in Blastomycosis"
Richard P. O'Neill, M.D., Lexington

11:00 a.m. "Laboratory Problems in Blastomycosis"
Coy Smith, Lexington

11:30 a.m. "Epidemiology of Blastomycosis in Kentucky"
Michael L. Furcolow, M.D., Lexington

12:00 noon Luncheon
"The World Health Organization and TB Control"
Kurt W. Deuschle, M.D., Lexington

CASE PRESENTATIONS

2:00 p.m. "Boeck's Sarcoid"
William H. Anderson, M.D., Thomas Stephenson, M.D.
J. Bruce Williams, Jr., M.D., Louisville

2:45 p.m. "Diagnosis of Systemic Fungus Infections"
N. A. Saliba, M.D., Louisville

3:35 p.m. "Use of Steriods in Uncommon Lung Disorders", "Clinical Findings in Enlarged Superior Mediastinum"
Fred J. Sigda, M.D., Madisonville

4:05 p.m. "Bronchiectasis in Children"
Paul M. Walstad, M.D., Harlan

4:35 p.m. Open Discussion

KENTUCKY THORACIC SOCIETY 1954

NTA

Application for six Prescribed hours has been made to the American Academy of General Practice



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

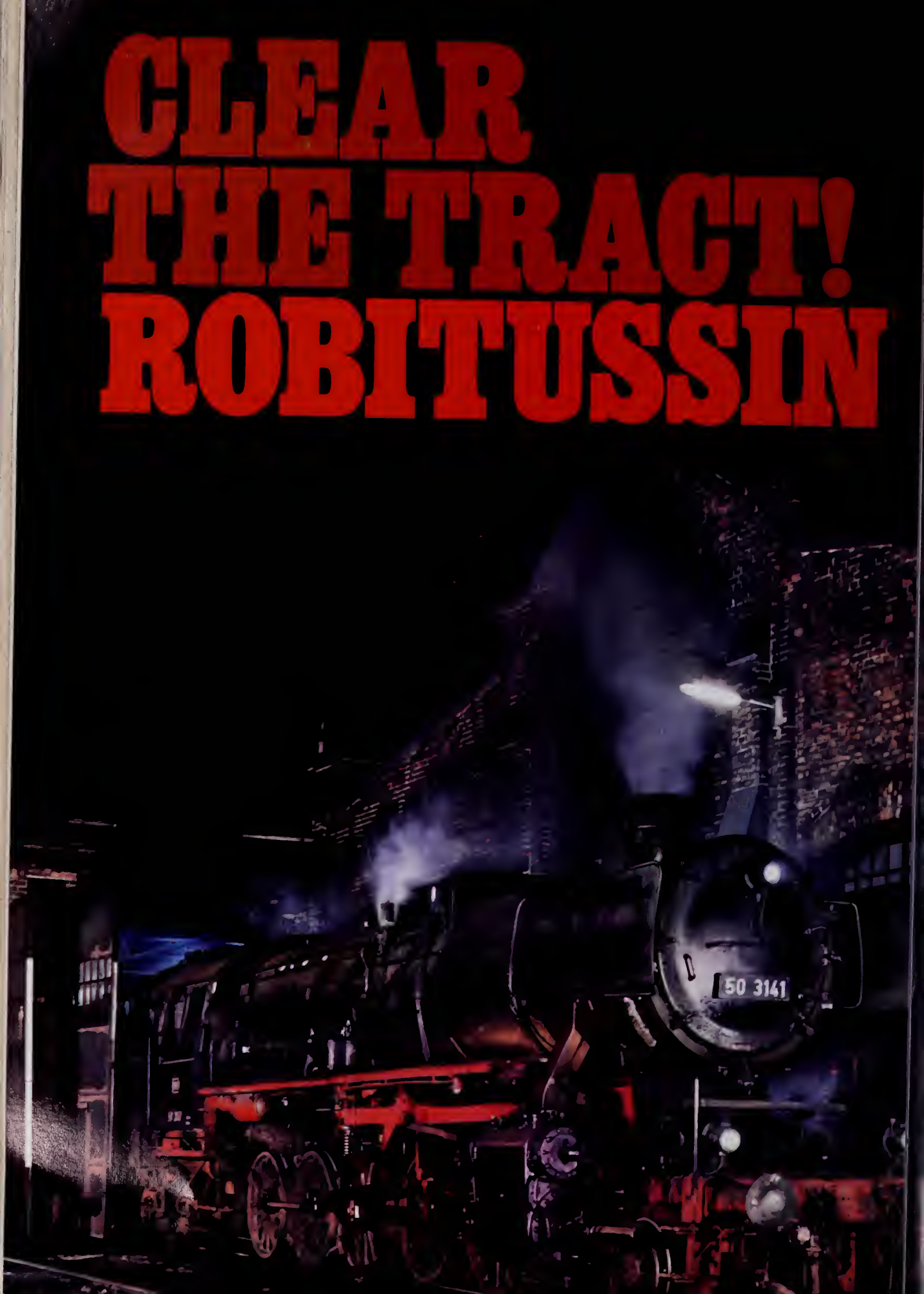
For acute, non-specific diarrheas **Donnagel® -PG** (Donnagel with paregoric equivalent). Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children. See product literature before prescribing.

A. H. Robins Company
Richmond, Va. 23220

A·H·ROBINS

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THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
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Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
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Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
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Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

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A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, av those responsive to routine measures as well as contraindicate p tients. Obtain a detailed history and a complete physical and labo examination, including a blood count. The patient should not e recommended dosage, should be closely supervised and shou warned to discontinue the drug and report immediately if fever, throat, or mouth lesions (symptoms of blood dyscrasia); sudden w gain (water retention); skin reactions; black or tarry stools or evidence of intestinal hemorrhage occur. Make regular blood c Discontinue the drug immediately and institute countermeasures white count changes significantly, granulocytes decrease, or imm forms appear. Use greater care in the elderly and in hyperten

Adverse Reactions: The most common are nausea, edema and rash. Swelling of the ankles or face may be minimized by withhc dietary salt, reduction in dosage or use of diuretics. In elderly pa and in those with hypertension the drug should be discontinued the appearance of edema. The drug has been associated with pept

›r 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the gonizing pain of shoulder bursitis.

s not for every patient. Check carefully the Contraindications, Warning and ·ecautions shown below.

ıd adverse reactions may occur. The most common are nausea, edema and rash. arely, agranulocytosis has been reported. All adverse reactions are listed below, too.

ay-for-pay or workaday patients—when they come up with shoulder bursitis and your inical judgment indicates Butazolidin alka—go with it.

ıd watch the comeback.



g* and may reactivate a latent peptic ulcer. The patient should be in- ucted to take doses immediately before or after meals or with y k to minimize gastric upset. Mild drug rashes frequently subside h reduction of dosage. However, rash accompanied by fever or er systemic reactions usually requires withholding medication. rpuric rash has also been reported. Agranulocytosis, exfoliative rmatitis, Stevens-Johnson syndrome, or a generalized allergic re- ion similar to serum sickness may occur and require permanent hdrawal of medication. Stomatitis, salivary gland enlargement, niting, vertigo and languor may occur. Leukemia and leukemoid actions have been reported. While not definitely attributable to the g, a causal relationship cannot be excluded. Thrombocytopenic rpura and aplastic anemia may occur. Confusional states, agitation, adache, blurred vision, optic neuritis and transient hearing loss have en reported, as have hyperglycemia, hepatitis, jaundice, and several ses of anuria and hematuria. With long-term use, reversible thyroid perplasia may occur infrequently. Moderate lowering of the red cell unt due to hemodilution may occur. 6509-V(B)R2

Butazolidin® alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York



Hemodynamics of Congenital Heart Disease

(Continued from Page 972)

Potts Operation which increases systemic arterial oxygen saturation. This procedure is a palliative measure and not curative, but is lifesaving until the infant attains a greater growth when complete correction is feasible. The obstructive lesions are completely correctable and are lifesaving within anatomical limits if surgically treated prior to progressive dilatation of the myocardium and failure.

Surgical measures for the palliation of transpositions, which can be lifesaving, involve the creation of an atrial septal defect to permit adequate mixing of oxygenated and unoxygenated blood and banding of the pulmonary artery, if there is increased pulmonary blood flow. Newer techniques for the creation of an atrial septal defect involve the passage of a ballon catheter between the right and the left atrium to dilate the small foramen ovale. The most promising procedure appears to be the technique devised by Mustard where the blood from the vena cavae is diverted to the left atrium and the oxygenated blood from the pulmonary veins is diverted to the tricuspid valve and the right ventricle.

Tricuspid atretic lesions may be palliated by the Blalock procedure. In older patients the procedure of Glen may be performed by anastomosis of the superior vena cava to the right pulmonary artery to divert the venous blood past the atretic tricuspid valve and the right ventricle which is often rudimentary. Success depends upon the capacity of the pulmonary circulation to accept the large blood flow from the superior vena cava.

Summary

A simplified discussion of the hemodynamics enables the physician to make a clinical diagnosis and be practical in the management of patients with heart lesions.

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fall 1967

DORSEY

Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air migl do this. A siege of smog in Denver, the "mile hig city," in December 1965 was accompanied by resp ratory infection that doubled normal absentee rat in schools, factories and city government.[10]

While air pollution is only one factor, it has becom important in the causes of most of the afflictions o the respiratory tract. This has been shown not on by the Denver occurrence, but also by detailed stud of respiratory illness in a small group of 313 me



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

For nature's hazards:
nasal congestion
due to seasonal
allergies and
summer colds



Triaminic® *syrup*

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these *side effects:* drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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How can he be a sport with a runny nose?



For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic It's ideal for summer allergies

1. Acts in 15-30 minutes due to decongestant.
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3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

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provide patient comfort

Triaminic® relieves summer allergies

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

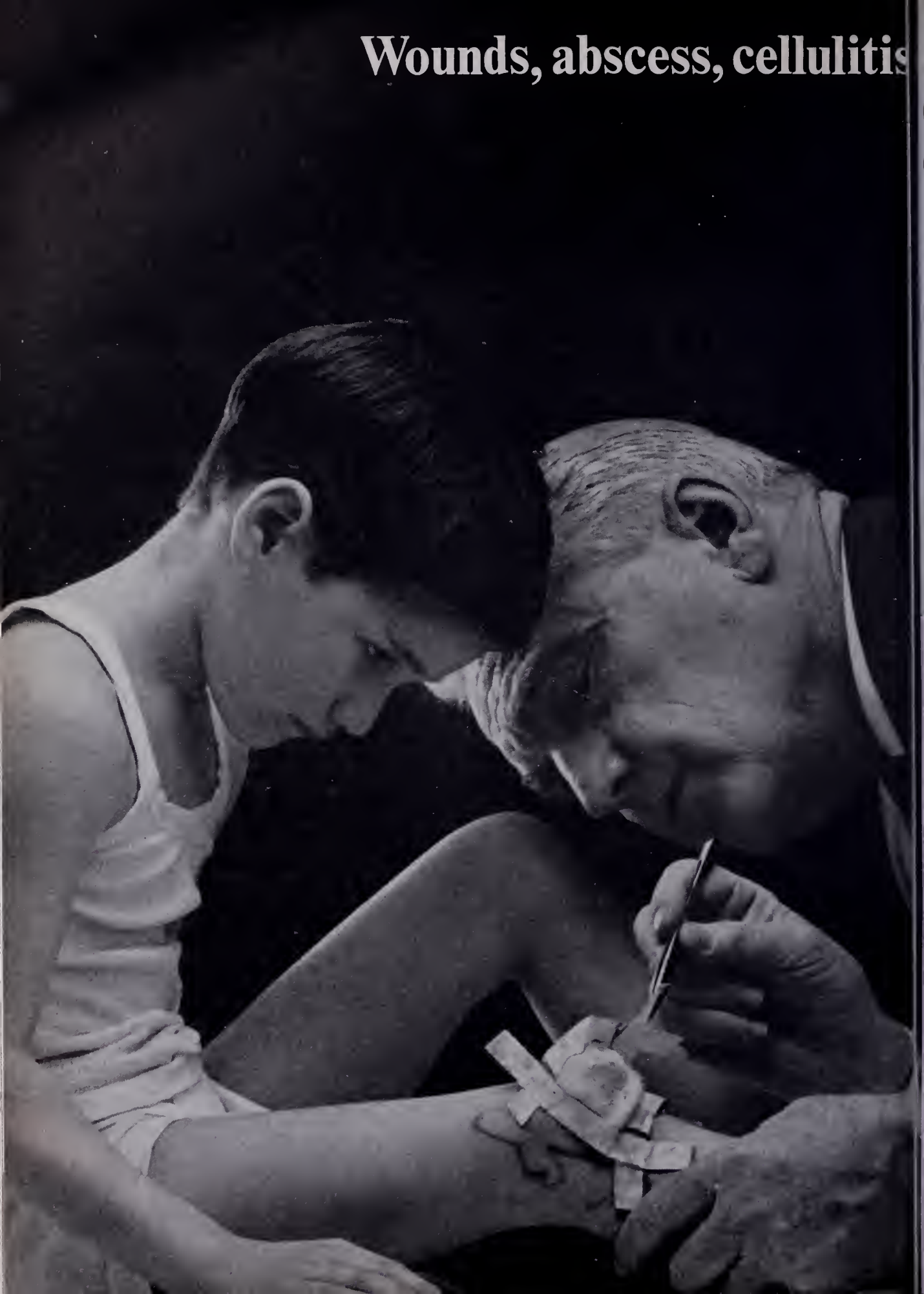
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



Wounds, abscess, cellulitis



...and the complications of staph.

From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

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Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

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There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo*, therapy with oxacillin can be extended when necessary.

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Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

Staph reliably controlled with specific therapy



A suitable dosage form for every staph situation

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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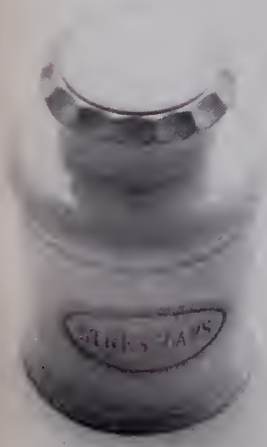
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B and C vitamins are therapy: STRESSCAPS B and C vitamins in therapeutic amounts... help the body mobilize defenses during convalescence... aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS capsules.



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Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg
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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
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Niacinamide	100 mg
Calcium Pantothenate	20 mg

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The full ¼ grain of phenobarb in the formula

takes the nervous edge off the pain ...helps bring out the best in codeine

Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate .....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

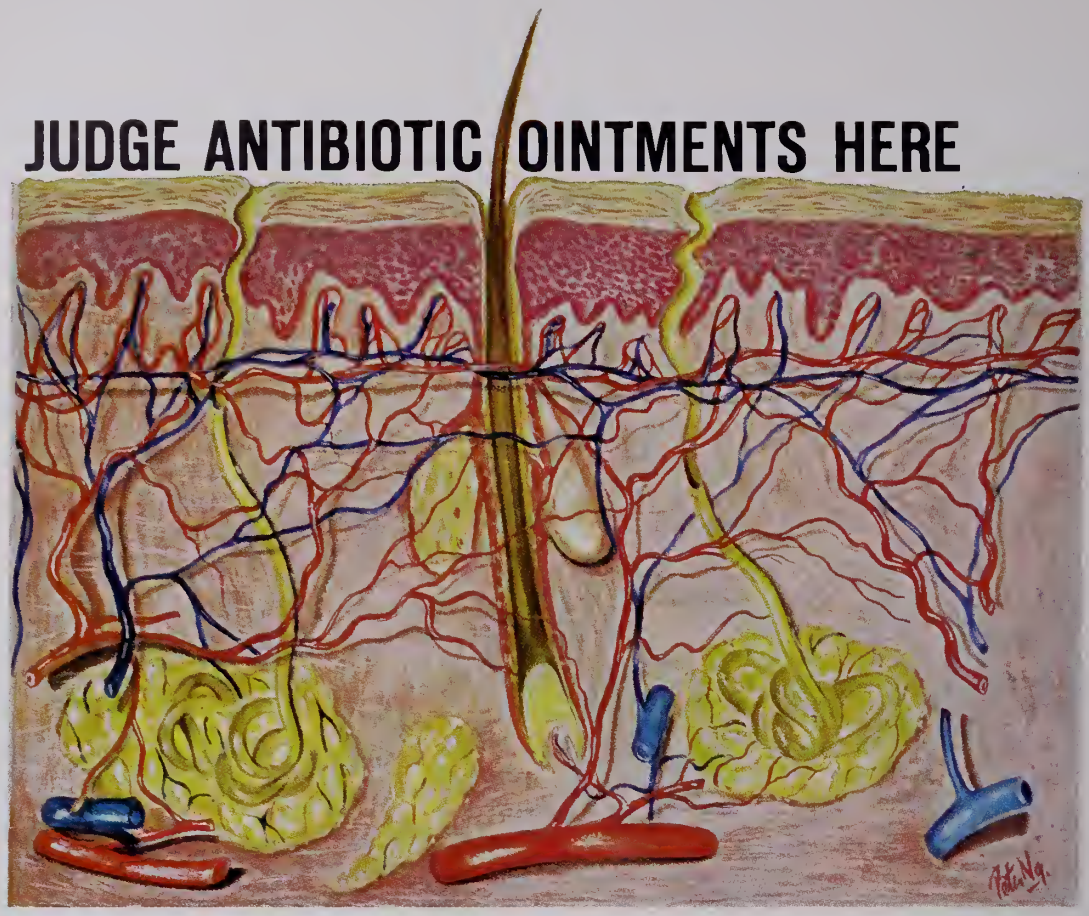
Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Dr. Bertram Resigns As Coroner

H. M. Bertram, Sr., M.D., Lewis County Coroner for 52 years, resigned from that post on August 8. Doctor Bertram, a Vanceburg physician, retired from private practice in 1955. However, he still conducts physical examinations for the Department of Economic Security and is chairman of the Lewis County Board of Health.

Dr. Whayne Assumes Federal Post

Harry U. Whayne, M.D., Murray, closed his practice August 25 to assume a position in Virginia with the federal government, according to published reports. Doctor Whayne, a past president of the Kentucky Academy of General Practice and a delegate to the American Academy of General Practice, had practiced in Murray for 15 years.

Maternal Mortality

(Continued from Page 958)

administration of a regular maintenance dose of Dilantin, the patient had a generalized seizure lasting about five minutes, with twitching most marked on the left side of the face and body. An airway was inserted. The pulse remained around 140. The rectal temperature was 97° and the blood pressure was 110/70. Nasal oxygen was started. The urinary output continued to be scanty.

Moderate vaginal bleeding was now noted. A fibrinogen level was reported as normal, as were bleeding and clotting times. The platelet count was 174,000. Blood was drawn for type and crossmatch. The blood count was 18 grams of hemoglobin, hematocrit 54, white blood count 24,100 with 58 per cent polymorphonuclear leukocytes. There was some icterus of the serum. A tourniquet was applied to her right leg and alternated on both legs. Her condition was described as critical. The eight hour intake was 1,580 cc, the output for the same period consisting of 200 cc of emesis and 550 cc of urine. She was digitalized because of a tachycardia of 160 per minute. The rectal temperature was 98.6° and the blood

(Continued on Page 1028)

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can yield excellent returns. Invest now in National Growth & Investment Co., Inc., which is negotiating to acquire two important investment properties in Louisville. Shares available at same price paid by original incorporators—local, respected businessmen. For prospectus and complete information, send your name and address to NGI, 420 W. Liberty, Louisville, Ky., or call 893-3434 after 6.



He leaves to make an urgent call But doesn't use the phone at all

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

(Continued from Page 1025)

pressure was maintained at 104/90 by the Levophed infusion.

The patient complained at intervals of pain in her arms. At 1:30 P.M. on March 21, 1966, no blood pressure was obtainable, and her arm became bluish with a white streak. A physician who was called to see her noted that she felt very cold to the touch, but complained of a feeling of warmth. The rate of the Levophed was increased and a blood pressure reading was obtained once more. The angiocath was changed. The blood pressure was now 80/60. Aramine was ordered added to the infusion. Her eight hour intake had been 150 cc all by intravenous infusion; the urine output was 175 cc for the same period. The 24 hour intake was 4050 cc intravenously; the urinary output was 900 cc. Her skin was cold to touch and she was perspiring. Difficulty was encountered performing a cutdown. Clinically she appeared jaundiced. Femoral puncture was attempted but was unsuccessful. The rectal temperature was 99°, and the blood pressure was now 90/70. At 3:15 P.M. she vomited fresh and coffee-ground material and complained of pain in the epigastric region. The blood pressure was once more unobtainable, as was the pulse. She developed a generalized blotchy, violet-bluish color. The abdomen was still soft. Three units of whole blood were administered under pressure, along with 3 ampules of Levophed in five per cent dextrose in water in a fast drip. The blood pressure never returned to recordable levels and the patient collapsed and died at 4:30 P.M. on March 21, 1966.

At autopsy, the gross diagnoses were: bilateral pulmonary congestion and edema; endometritis with retention of placental fragments; possible adrenal hemorrhage; possible hepatorenal syndrome secondary to clinical diagnosis of E. coli septicemia; old healed tuberculosis. The microscopic diagnoses were: E. coli septicemia; acute endometritis with retention of placental tissue; non-specific reactive hepatitis; toxic nephrosis; acute pulmonary edema and congestion; and congestion of the adrenals.

Comments

The members of the Committee were of the opinion that this case should be classified as a direct obstetric death with preventable features for which the attending physician would appear to have been responsible. There may have been insufficient concern regarding the hazards of premature rupture of the membranes; this complication is a potentially serious cause of severe amnionitis and demands early and vigorous treatment, and the Committee thought the induction procedure might well have been undertaken earlier in this patient. When the full-blown picture of septic shock had developed, the management was less aggressive than recent experience reported in the literature indicates. In particular, the use of Levophed and Aramine for the restoration of the peripheral blood pressure is questionable, since these drugs cannot correct the deficient perfusion of vital organs which is responsible for the eventual irreversibility of the shock. Early administration of large doses of corticosteroids has proved a more useful adjunct in the management of these cases than has the infusion of pressor drugs. Heavier antibiotic dosage was also indicated in this case. Despite these critical comments, the Committee acknowledged the extremely serious problems raised by the case and the conscientious care and attention which were clearly provided by the attending physician.

NEWS ITEMS

William H. Keller, M.D. is now associated with Thomas H. Baker, M.D. in Frankfort, limiting his practice to obstetrics and gynecology. Doctor Keller graduated from the University of Cincinnati College of Medicine in 1961 and completed his internship and residency training in Cincinnati hospitals.

Chrisman S. Jackson, M.D. was recently named superintendent of Outwood State Hospital and School, Dawson Springs, by Dale Farabee, M.D., Kentucky Commissioner of Mental Health. Doctor Jackson has been a staff physician at Outwood since August, 1966.

Philip D. Hitchcock, M.D., Bowling Green, has been named to serve as county health officer for Simpson, Allen, Butler and Edmonson counties, according to a recent announcement by the Kentucky Department of Health.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A

When the agitated geriatric disrupts the home...

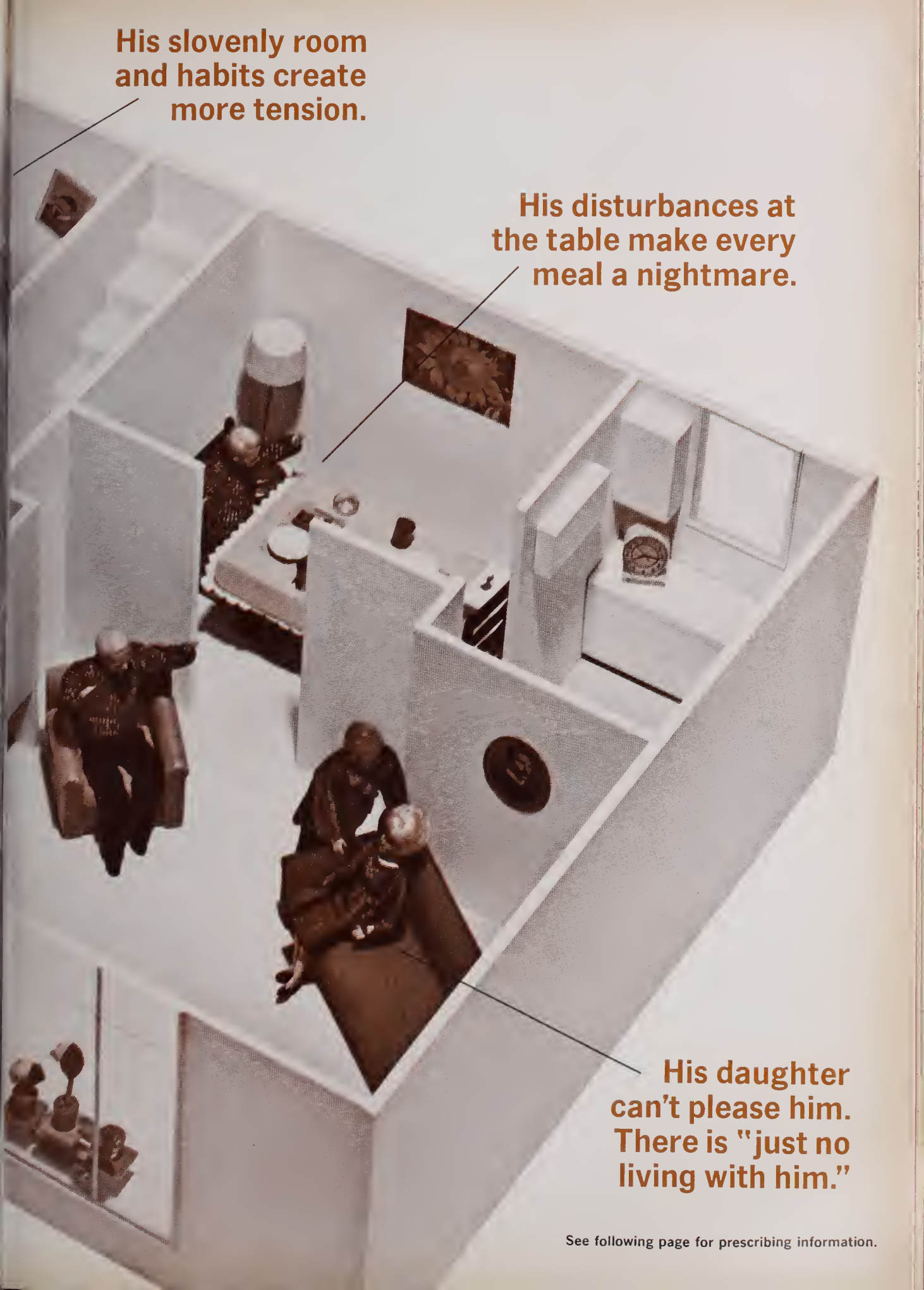
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THE INSURANCE PAGE



The National Conference on Health Care Costs

WITH the massive entry of the federal government into the health care field, more and more political concern is being voiced about health costs and effectiveness. Social welfare, defense, education, and health programs are now competing for tax dollars, and although "group practice" and "area wide planning" are unfamiliar words to politicians, "higher taxes" are not.

The recent two-day National Conference on Medical Costs emphasized this Congressional concern for health costs. The meeting brought together 300 participants representing doctors, nurses, hospitals, nursing homes, government and voluntary agencies, and insurance companies in Washington. The conference followed the usual HEW pattern. An opening session heard federal officials define, if not the problems, then the preferred approaches to them. The delegates then gathered to five preassigned discussion groups: hospital costs, community systems, physician costs, drug costs and third party payment. Following this, they reassembled in a final session where discussions were summarized and a final pep talk was given by HEW secretary John W. Gardener.

There is little question that one of the principal problems facing the health field today is the organization and financing of health services. There is also little question that our health services systems and institutions have in some ways failed to keep pace with the increasing complexity of health care and the changing health needs of the nation.

While all kinds of suggestions and ideas were offered by the participants, most of the suggestions were, at best, combinations of old ideas. No new or original solutions were proposed and the general conclusion reached is that no simple solutions exist for the complex problems involved in lowering costs while maintaining the quality of medical services.

Secretary Gardener, in his closing speech, said the conference represented a new phase in national discussions. The new emphasis is on examining "the efficiency, the productivity, and the logic of the system by which care will be delivered." Everyone sees shortcomings, Mr. Gardener continued, but no agreement exists on what a better system would look like. "Those who entertain some apprehension as to what the new patterns will be had better plunge in and experiment with their preferred solutions. Standing back and condemning the solutions that others devise won't stem the tide of change."

The Secretary said responsibility for devising solutions must be widely shared among all groups involved in the delivery of health care, adding, "such a widely accepted sense of responsibility is the best insurance against the government having to shoulder more than its share of corrective measures."

These words of advice would appear to be particularly appropriate counsel for the physicians of this country.

WILLIAM W. HALL, M.D.

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Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
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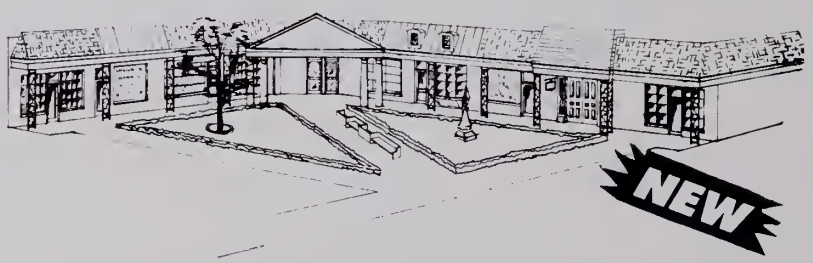
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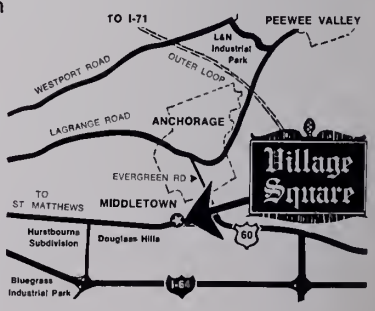
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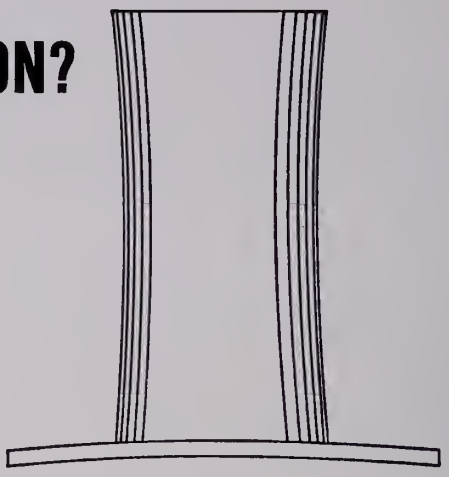
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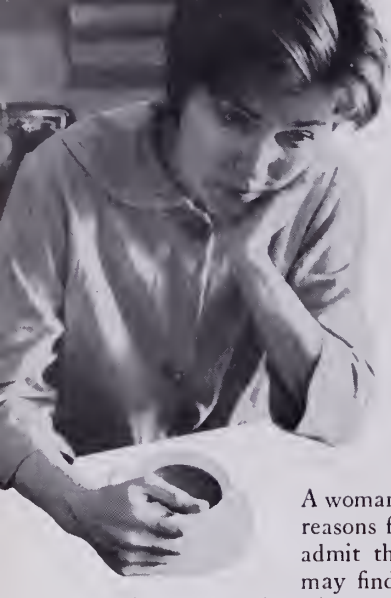


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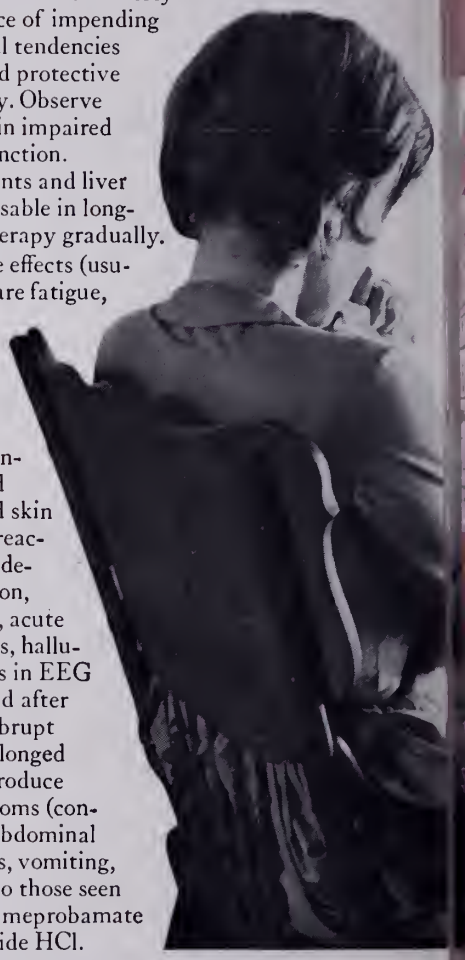


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Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, un correct maintenance dosage is established, advise patien against possibly hazardous procedures requiring complete me tal alertness or physical coordination. Driving during therap not recommended. In general, concurrent use with other psych tropic agents is not recommended. If such combination therap is used, carefully consider individual pharmacologic effects particularly with known compounds which may potentiate a tion of Valium (diazepam), such as phenothiazines, barbiturat MAO inhibitors and other antidepressants. Advise patien against simultaneous ingestion of alcohol or other CNS depre sants. Safe use in pregnancy not established. Employ usu precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.



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Dosage: *Adults:* Mild to moderate psychoneurotic reactions, to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 1 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 2 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm wit cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatr patients:* 1 or 2 mg/day initially, increase gradually as neede and tolerated. (See Precautions.)

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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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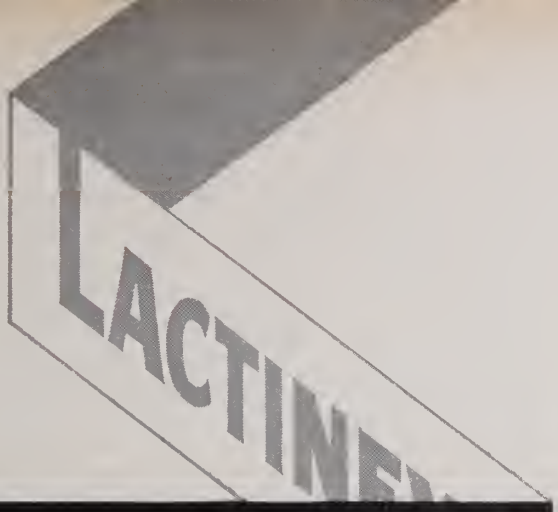
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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MESSAGE FROM THE PRESIDENT



Volunteer Physicians for Viet Nam

IT WAS very pleasing to receive recently a letter from AMA President Milford O. Rouse, M.D., enthusiastic about the success of the AMA Volunteer Physicians for Viet Nam Program, and asking all state societies to encourage their members to participate.

It is now general knowledge that in the summer of 1965 the government of South Viet Nam was on the verge of collapse. Among the measures of American support they requested of the Johnson Administration was medical care for the civilian population, as a tool for winning the minds of the people—the so-called second war, or the pacification program.

President Johnson in turn requested the AMA to secure the services of American physicians. Considering the American medical manpower shortage, it was decided that two-month tours of duty by American clinicians would provide the greatest service to the Vietnamese with the least hardship at home. The volunteers were offered transportation, no salary, and $10 a day subsistence.

The program has been so successful that the AMA now has in Viet Nam, at any one time, 30 American physicians at 20 province hospitals. Expansion of the program calls for 50 physicians in the country by the end of this fiscal year. Well over 300 physicians have served two-month tours by now.

I am eternally grateful that my circumstances permitted me to help get the program off the ground. The need of the Vietnamese was, and is, tremendous. The State Department and the government of South Viet Nam have done all that could possibly be expected to carry out the improvements we have suggested in the program. It has come a long way since a lonesome nine of us, in September, 1965, were sent to the boon-docks with the frank advice, "It's more primitive than you can possibly imagine—just go and do the best that you can."

I can heartily recommend this program to any of our members.

George F. Brockman



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

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(initial adult dose)

ndications: Urinary tract infections caused by gram-negative and some gram-ositive organisms.

lde effects: Mainly mild, transient gastrointestinal disturbances; in ccasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild osinophilia, reversible subjective visual disturbances (overbrightness of ghts, change in visual color perception, difficulty in focusing, decrease in isual acuity and double vision), and reversible photosensitivity reactions. larked overdosage, coupled with certain predisposing factors, has produced rief convulsions in a few patients.

recautions: As with all new drugs, blood and liver function tests are advis-ble during prolonged treatment. **Pending further experience, like most hemotherapeutic agents, this drug should not be given in the first trimester f pregnancy. It must be used cautiously in patients with liver disease or evere impairment of kidney function.** Because photosensitivity reactions have ccurred in a small number of cases, patients should be cautioned to avoid nnecessary exposure to direct sunlight while receiving NegGram, and if a eaction occurs, therapy should be discontinued. The dosage recommended or adults and children should not arbitrarily be doubled unless under the areful supervision of a physician. Bacterial resistance may develop.

/hen testing the urine for glucose in patients receiving NegGram, Clinistix® eagent Strips or Tes-Tape® should be used since other reagents give a lse-positive reaction.

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leferences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on equest. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: ntimicrobial Agents and Chemotherapy—1964, Ann Arbor, American ociety for Microbiology, 1965, p. 722.

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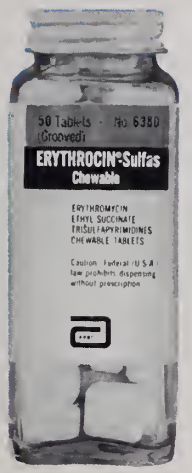
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]...However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.



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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

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Brief Summary

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Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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up to 10-12 hours clear breathing on one tablet



PUBLIC HEALTH PAGE

A Year of Cervical Cancer Screening†

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

ON JULY 1 of this year the State Department of Health completed its first year in the development of a cervical cytology screening program for Kentucky. Through the support of the state's medical community, this was made possible by a special legislative appropriation. The Cancer Coordinating Committee of the Kentucky Medical Association served to advise the State Department of Health in the design of the program. The resulting cervical cancer screening program was subsequently endorsed by the Kentucky Medical Association and the Kentucky Academy of General Practice. The primary purpose of the program is to teach women, by doing, the importance, value, simplicity and effectiveness of a yearly Papanicolaou smear. Since case-finding is a secondary objective, the program is not directed to high-risk populations, *per se*.

The cervical cancer screening program is actually a composite of many individual county programs. Presently 78 counties have approved the operation of some type of cervical cancer screening program. While the State Department of Health furnishes guidelines and assistance to local communities in establishing a cervical cancer screening program, the actual design of each county program is determined by the local medical community, according to the needs, facilities and interests in that community. The Cancer Program of the State Department of Health also assists local programs by furnishing necessary clinic supplies and forms, by providing for cytology interpretations by private pathologists, and by providing for training in the Papanicolaou smear technique for registered nurses, where nurses are used in a particular local screening program. In addition, the Cancer Program maintains a master file of each county's follow-up file to assure that no patient is lost to follow-up. Reports of the Papanicolaou smears done through this program are sent to each patient's private physician, who then determines whether or not diagnostic tests, treatment, or referral are indicated.

Over 6200 Papanicolaou smears were done through this program this first year. The monthly total increased exponentially, from 17 the first month to 1120 the last month, as programs in various counties became operative.

Forty-four percent of the women screened were from Appalachian counties, which may account for the facts that nearly half the screenees came from families having less than $2,500 annual income, and over half had not entered the tenth grade. Even though a relatively young age group prevailed (60% under 40 years of age) a rate of 5.4 cases of cervical cancer per 1,000 screenees was determined, with a rate of 5.8 cases of total genital cancer per 1,000 screenees. Two screenees having vaginal carcinoma detected had both received previous hysterectomies for non-invasive carcinoma of the cervix. Fortunately, 85% of the cervical carcinomas were in the in-situ stage. Nearly 16% of the screenees showed some type of abnormality other than a suspected malignancy (i.e., trichomonas, inflammation, atypia, etc.).

Even though a creditable service in terms of early casefinding has been accomplished, a major benefit of the program has been its educational value. Two-thirds of the screenees had never received a Papanicolaou smear previously. Women in the "over 70" and "under 25" age groups had the lowest percentages of previous Papanicolaou smears. The latter group comprised 22% of the population tested. It was also learned that women of rural groups were least likely to have received a previous Papanicolaou test, regardless of income or education, although low income and low educational levels also decreased the likelihood.

A need for even greater physician participation in patient health education and motivation was demonstrated. Three-fourths of the screenees who had received a previous Papanicolaou smear from their private physician were overdue for another. Two-thirds of the women who had received a previous smear during hospitalization or some source other than their private physician or health department were overdue for another. One-third of the women who had received an intrauterine device as a contraceptive means believed they had never had a Papanicolaou smear, while 60% of the screenees who had used an oral contraceptive reported they had never had this test. In contrast, some women believed they had received several Papanicolaou tests because they had submitted urine specimens in the past.

(Continued on page 1139)

†*This article was prepared by Donald F. Austin, M.D., Cancer Control Officer, Kentucky State Department of Health, 775 East Main Street, Frankfort, Kentucky 40601.*



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: With the administration of enteric- potassium supplements, which should only when adequate dietary supple- on is not practical, the possibility of wel lesions (obstruction, hemor- nd perforation) should be kept in urgery for these lesions has fre- been required and deaths have oc- Discontinue enteric-coated potas- pplements immediately if abdominal stention, nausea, vomiting, or gastro- l bleeding occur.

caution in pregnant patients, since may cross the placental barrier and reactions which may occur in the rombocytopenia, hyperbilirubinemia, carbohydrate metabolism, etc.) are l problems in the newborn.

ions: Antihypertensive therapy with n should always be initiated cau- n postsympathectomy patients and nts receiving ganglionic blocking r other potent antihypertensive drugs, e. Reduce dosage of concomitant rtensive agents by at least one-half. ates, narcotics or alcohol may po- hypotension. Because of the possi- progression of renal damage, peri- ermination of the BUN is indicated. nue if the BUN rises or liver dysfunc- gravated. Hepatic coma may be ated.

yte imbalance, sodium and/or potas- pletion may occur. If potassium deple- uld occur during therapy, Hygroton e discontinued and potassium sup- s given, provided the patient does marked oliguria.

ecial care in cirrhosis or severe c heart disease and in patients re- corticosteroids, ACTH, or digitalis. riction is not recommended.

Reactions: Nausea, gastric irritation, , anorexia, constipation and cramp- iness, weakness, restlessness, hy- emia, hyperuricemia, headache, mus- ps, orthostatic hypotension, aplastic leukopenia, thrombocytopenia, ocytosis, impotence, dysuria, transient skin rashes, urticaria, purpura, nec- angiitis, acute gout, and pancreatitis igastric pain or unexplained G.I. ns develop after prolonged adminis- Other reactions reported with this compounds include: jaundice, xan- paresthesia, and photosensitization.

Dosage: One tablet with breakfast every other day.

lity: White, single-scored tablets of and aqua tablets of 50 mg., in bot- 00 and 1000. (B)46-230-D

details, please see the complete ing Information.

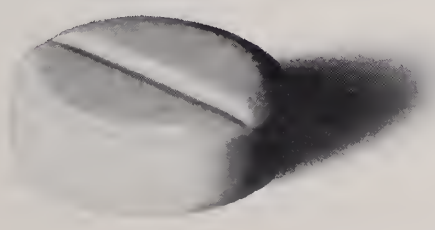
harmaceuticals of hemical Corporation New York

Here's the Hygroton they don't have to halve



New Hygroton 50 mg. from Geigy

to go with the Hygroton 100 mg. you know



HY-5406

When the agitated geriatric disrupts the home...

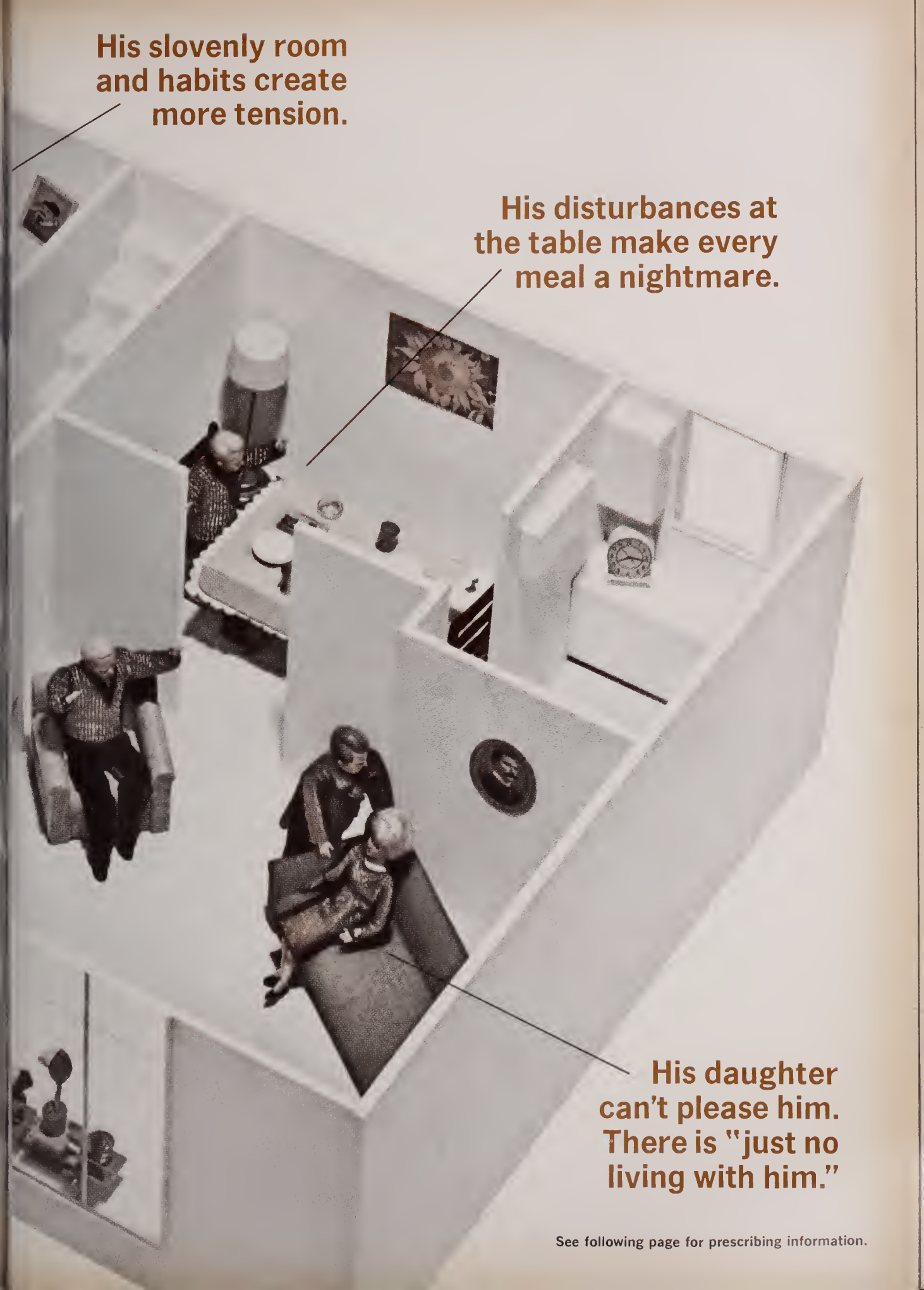
His teen-age granddaughter won't invite friends home because of his outbursts.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



THE INSURANCE PAGE



CHAMPUS

THE Department of Defense has made a major change in its system of payment for the medical care of military dependents. Influenced by the Title XVIII program, the department has scrapped its system of contracts with medical societies and the schedules under which it sought to control physicians' fees for the care of military dependents.

A few months ago, the Defense Department began to permit "usual and customary" fees, but it has now gone a step further, patterning virtually the entire payment structure of "Military Medicare" on the model of the Medicare system. About six million persons are now covered by the dependents' program, which will cost some $200 million this year.

The change had previously gone into effect in the 12 states where no contract existed with medical societies. The remaining states are coming under the new plan when present contracts expire. In Kentucky the plan was delayed until the KMA fee survey was completed.

Nationwide, the bills for physicians' services will be sent to the fiscal intermediary that represents the military dependents medical program. In 19 states, the carrier is the same as the Social Security Medicare carrier; in Kentucky, Blue Cross-Blue Shield will administer the program.

The CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) program will pay "usual and customary" fees to Kentucky physicians for their services to eligible beneficiaries. Usual and customary fees will be paid for physicians' services rendered on or after October 1, 1967. These fees are based on the recent fee survey conducted jointly by KMA and Blue Shield. These fee levels will be reevaluated at least every two years and revised as necessary to accommodate increased costs, etc.

In case a physician's charge exceeds the usual and customary limits it will be referred to the KMA CHAMPUS review committee for ultimate settlement.

Covered benefits have been greatly expanded to include not only hospital services, but most out-patient services such as diagnostic examinations, prescription drugs, physical therapy as well as home and office calls. For this the military dependent must pay an initial deductible sum during each fiscal year (July 1 to June 30). CHAMPUS pays 80% of the remaining charges for out-patient services for dependents of active duty members, or 75% of the charges for retired members and their dependents or dependents of deceased members.

It appears that this program will be a great improvement over the old military dependents program. From this aspect, at least, the joint fee survey has been of much benefit to the physicians of Kentucky.

WILLIAM W. HALL, M.D.

Dulcolax®

sacodyl

DU-5255 R

ew drugs work as predictably
s Dulcolax. You can expect
iat when your office patient
ikes Dulcolax at home, it will
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vould be. Your patient will be
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he reliability of Dulcolax
tems from its unique mode of
ction. The drug works
irectly on nerve endings in
ie colonic mucosa, producing
ormal peristalsis throughout
ie large intestine. It does
ot rely on systemic absorption
or its effect.

his reliable action provides
rompt relief of constipation.
also makes Dulcolax par-
ticularly useful for prepping the
bowel for special procedures.
In short, it makes Dulcolax
ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

neral Dosage Information: *Adults:* When an ordinary laxative effect desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets st be swallowed whole, not chewed or crushed, and should not be en within one hour of antacids or milk. *Children:* 1 or 2 tablets, pending on age and severity of condition. Tablets must not be given a child too young to swallow them whole. For infants and children der 2 years of age, half a suppository is usually effective. Above this e a whole suppository is usually advisable. Side Effects: As with any ative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

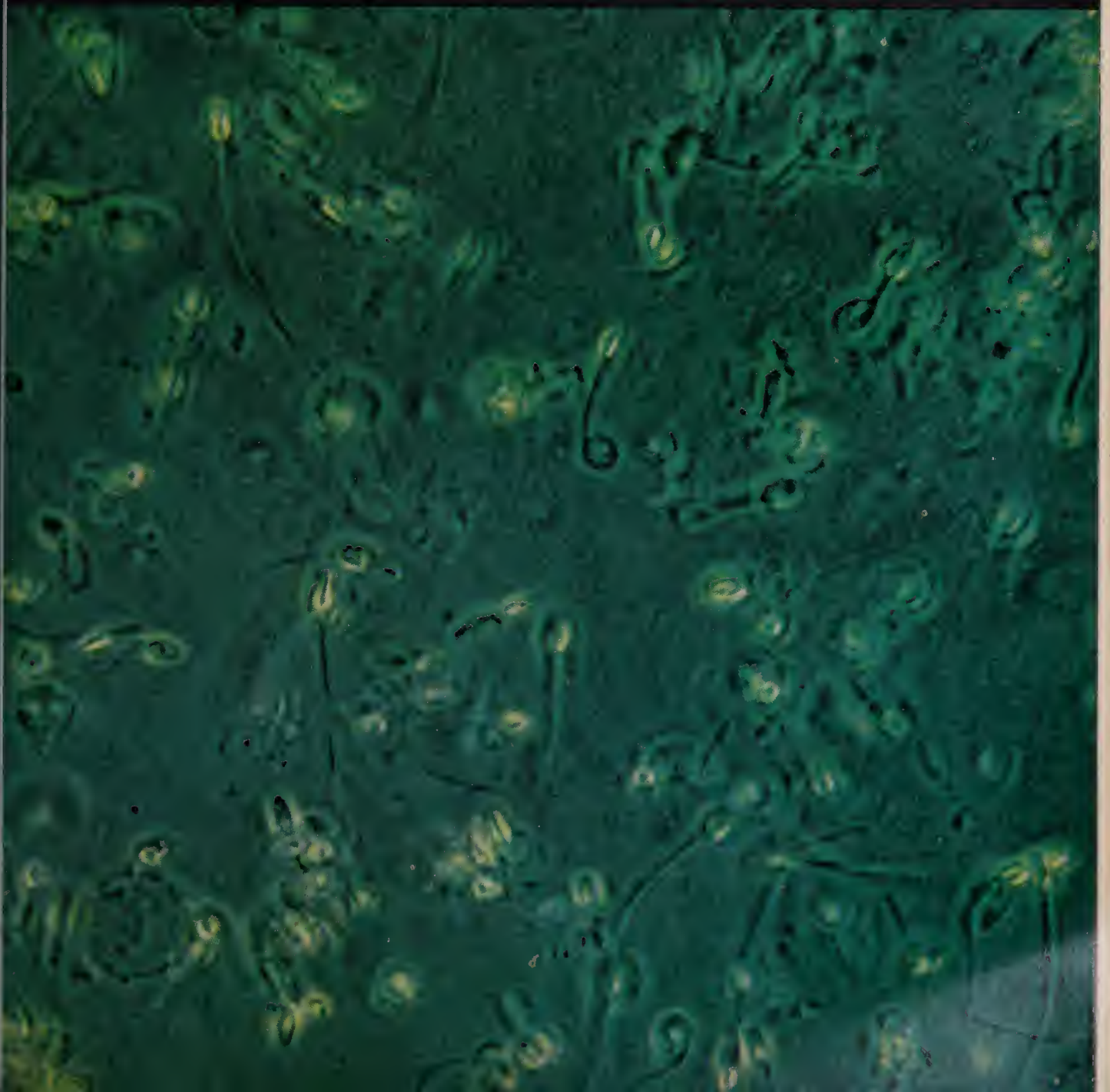
■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incide in patients receiving oral contrace tives: nausea, vomiting, gastroint tinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, eder chloasma or melasma, breast char (tenderness, enlargement and secretion), change in weight (incre or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when giv immediately postpartum, cholest jaundice, migraine, rash (allergic) rise in blood pressure in susceptib individuals, mental depression. Although the following side effec have been reported in users of ora contraceptives, no cause and effec relationship has been established anovulation posttreatment, preme struallike syndrome, changes in libido, changes in appetite, cystiti like syndrome, headache, nervous ness, dizziness, fatigue, backache hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. The following occurrence have been observed in users of ora contraceptives (a cause and effect relationship has neither been esta lished nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

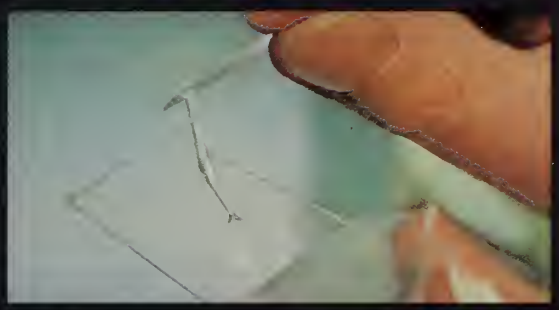
The following laboratory tests ma be altered by the use of oral contr ceptives: increased sulfobromophthalein and other hepatic funct tests, coagulation tests (increase i prothrombin, factors VII, VIII, IX and X), thyroid function (increase PBI and butanol extractable prote bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

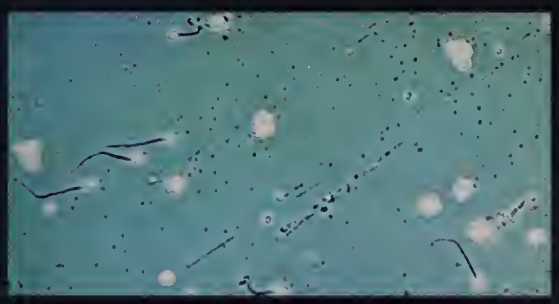
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

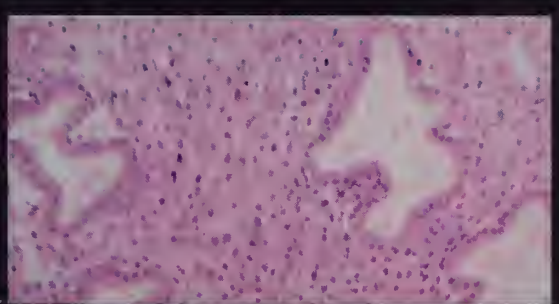
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

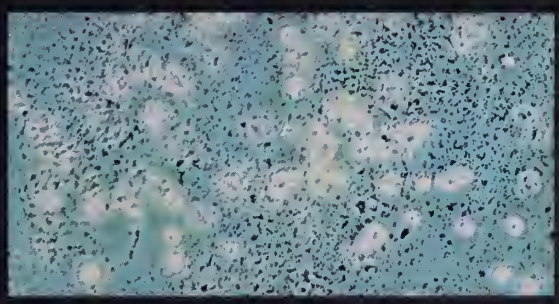


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

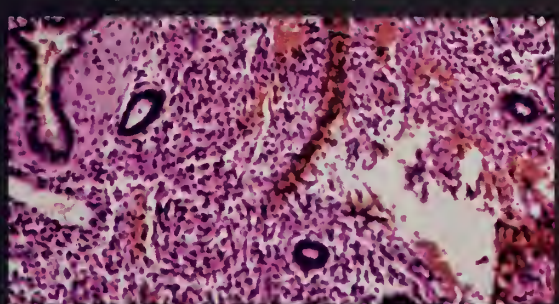
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. & mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar
fluocinolone acetonide





Turn page for contraindications, precautions and side effects.

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide — an original steroid from

SYNTEX

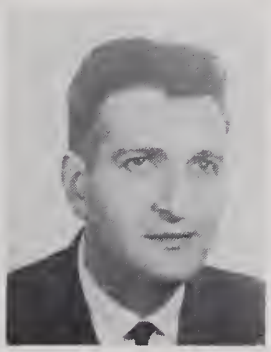
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The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 65 November 1967 No. 11

Myelomeningocele: A Report of Ninety-two Patients Being Cared for by the Commission for Handicapped Children

J. KENNETH EAKINS, M.D.* and MARGARET A. LIMPER, M.D.**

Louisville, Kentucky

Ninety-two patients with myelomeningocele are being seen in clinics of the Commission for Handicapped Children. Special attention is called to their urinary problems. A special clinic is being established to provide comprehensive care.

THERE is probably no patient who presents the physician with a more formidable problem than does the newborn infant with a myelomeningocele. The term myelomeningocele refers to a congenital defect characterized by lack of fusion of vertebral arches, most commonly in the lumbar and/or sacral region, with herniation of meningeal and neural elements. In addition to herniation there may also be a defect in the spinal cord itself. Deficit innervation of the body below the level of the lesion is usually present.

The problems of a patient with this defect are many and varied. The care provided is often dependent upon the philosophy of the attending physician. In the past, many physicians have felt that the presence of paraplegia and loss of normal sphincter action found in most of these babies was a contra-indication to surgical repair of the myelomeningocele. With the advent of antibiotics for the control of infection and of improved shunting procedures for the control of hydrocephalus, an increasing number of physicians now routinely repair these defects. Indeed, there is a trend now to regard this as an emergency procedure to be completed within the first 24 to 48 hours of life.[1,2] It is felt that early surgery may preserve some innervation to the lower body.

Hydrocephalus, manifest at birth or becoming apparent sometime thereafter, occurs in a majority of these patients.[3] Posing a constant threat to life and normal development, this requires specialized neurosurgical observation and treatment.

Orthopedic care is required for the management of the paraplegic condition and the frequently occurring clubfeet and dislocated hips.

Normal bowel function is usually disturbed. Chronic constipation is the rule and rectal prolapse may occur. Management is usually of a conservative nature.[4]

The most insidious problem is that resulting from involvement of the urinary tract. This is also one of the most important areas of physician responsibility since ". . . complications in the urinary tract are the over-riding cause of death in the child who survives the hazards of hydrocephalus and meningitis in infancy."[5]

The purpose of this paper is to report the results of a review of the medical records of all children with a myelomeningocele who are cur-

*Pediatric Consultant, Commission for Handicapped Children, Louisville, Kentucky
**Medical Director, Commission for Handicapped Children, Louisville, Kentucky

rently under the care of the Commission for Handicapped Children. Special attention has been focused on the status of the urinary tract of these patients. It is hoped that attention can be called to the need of these children for careful attention to their urinary tract and to the need of a comprehensive, team approach in the management of these patients.

Findings of Review

As of March 1, 1967, 92 patients with the substantiated diagnosis of myelomeningocele were under the care of this agency. The majority of these were being seen by physicians in clinics in Louisville, but a few were being followed in Commission clinics in Ashland, Covington, Lexington and Paducah. Care was being provided in one or more of the following types of clinics: neurosurgical, orthopedic, seizure, eye, and plastic surgery. No patient was included who had not been seen for two years. Most patients had been seen within a few months. The age span was six months to 20 years with 66 of the patients less than nine years old. The following tables tabulate the main findings.

Discussion

TABLE I

PATIENTS ACCORDING TO RACE AND SEX

	No. of Patients
Male	44
Female	48
Caucasian	86
Negro	6

It is noted, in Table I, that only 6 (6.5%) of the patients are Negroes. However, in 1966, 16.9% of all the children seen by this agency were Negroes. A recent report from Vanderbilt reports an unusually low percentage of Negro patients with myelomeningocele.[6]

TABLE II

ASSOCIATED PROBLEMS

	No. of Patients
Hydrocephalus	38
Mental Retardation	17
Strabismus	16
Skin Ulcerations	27

Table II indicates that only 38 of the 92 patients are known to have hydrocephalus. Fourteen of these have had a shunt procedure. The majority of the others have mild, arrested hydrocephalus. Only 17 patients are known to be mentally retarded. However, it is likely that psychological testing of the entire group would reveal a higher percentage of mental retardation.

TABLE III

UROLOGIC CARE PROVIDED

	No. of Patients
Never seen by urologist	45
Specialized Urologic Care	47
Private Care	10
Early, Consistent Care	11
Late, Consistent Care	13
Inadequate Care	13

The chief concern of this paper is with the findings presented in Tables III and IV. The Commission for Handicapped Children has no urologic clinic but can arrange for children to have urologic consultation with specialists in this field. Forty-five of the patients have never had the benefit of this service, and many of these have never had a urinalysis performed. By and large, their urinary problems have not been recognized. Forty-seven patients have been seen by an urologist. In 10 patients this care was obtained through private sources and in 37 patients the care was obtained under the auspices of the Commission. Eleven of these latter patients began consistent urologic care within one year after being accepted by this agency. In Table III, this is referred to as "early" care. However, there is evidence that children with this defect often have demonstrable urinary tract pathology at a very early age. For example, Harlowe, et. al.[7] found in a group of 55 patients between one day and six weeks of age that 53% had positive urine cultures, 54% had residual urine, 63% had an abnormal cystogram, 29% had an abnormal IVP, and 9% had an elevated BUN. It is evident that these children require careful scrutiny of the urinary system from birth. In 13 patients in our series, referral was delayed for longer than one year, but consistent follow-up was finally achieved. In another 13 patients adequate follow-up has never been achieved, primarily because of poor parent cooperation.

TABLE IV

STATUS OF URINARY TRACT

	No. of Patients	
Apparently Normal	3	
"Minor" Problem	5	
"Major" Problem	50	
Ileal-loop Bladder	13	(4 others planned)
Urinary Status Unknown	34	

Table IV presents in a general way the status of the urinary tract in these 92 patients. In 34 cases not enough information could be obtained

from the record to indicate the condition of the patient. An attempt is now being made to assess these patients. Fifty patients, including some never seen by an urologist, were obviously having major urinary problems. These problems include incontinence, recurrent and chronic urinary tract infections and, in many cases, radiographic evidence of hydronephrosis. Thirteen of these children have had an ileal-loop bladder constructed and this procedure is planned in four other cases. In only eight patients was there little or no urinary tract dysfunction.

It seems obvious that many of these children have not received optimal care with reference to the urinary system. In addition to lack of referral for specialized care, such items as routine urinalysis and instruction in Crede of the bladder were generally omitted. There are a number of reasons for this failure. First, many physicians continue to be unaware of the magnitude of the urinary problems in these patients. This results partially from the often insidious nature of the involvement plus the infrequency of these patients in the practice of the private physician. Second, many of the patients considered in this report are being followed in orthopedic clinics. These tend to be large clinics, and the physician's attention naturally tends to focus upon other major problems exhibited by the child. Third, the care of most of these patients has been divided among two or more clinics, and no one has been in charge of coordinating the total care and watching out for the over-all needs of the child.

The Commission for Handicapped Children is now making plans to establish a separate clinic for the care of children with myelomeningocele. Ames, discussing the program established for the care of similar children at the Children's Hospital of Philadelphia, states that "the child born with myelomeningocele is the classic example of the necessity of collaboration and co-operation of the various specialties in a well-co-ordinated team."[8] It is hoped that the clinic can be staffed with a neurosurgeon, an orthopedist, a pediatrician, and an urologist. In addition, nursing, physical therapy and social service will be represented. Special services that become necessary, such as opthalmology, will be provided on a consultation basis. It is believed that all the many facets of care required by these patients can be expedited and improved through the formation of a clinic of this type.

Summary

Ninety-two patients with myelomeningocele are currently being provided care in the clinics of the Commission for Handicapped Children. A review of their medical record reveals that many of these patients with known or assumed urinary tract problems have not received specialized urologic care. Since these patients have

(Continued on page 1140)

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Microsurgical Technique for the Cataract Incision

Herbert P. Hargett, M.D.*

Jeffersonville, Indiana

Microsurgical techniques result in fewer complications due to inaccuracies in operative technique, previously unavoidable or unrealized. Main advantages, utilizing the operating microscope include accurate point apposition, precise placement of forceps and needles in corneal and scleral borders, and minimal surgical trauma.

A METHOD for making a planned, measured cataract incision and a precise and exact procedure for suturing it, utilizing the operating microscope, will be described. The techniques used have been advocated by well known ophthalmic surgeons. The purpose of this paper is to show how these techniques can be combined and modified to the use of the operating microscope. These microsurgical techniques have given better results for me, with fewer complications due to inaccuracies in operative technique. These inaccuracies have been previously unavoidable, or unrealized.

The microscope is not difficult to use. After some hours of practice the bothersome false projection disappears, and the surgeon can give his full attention to the operative field. The microscope enables the incision to be controlled within 0.1 and 0.2 m.m., and the incision to be closed with precise apposition.

Technique

The preoperative and preliminary operative steps are the same as those used in conventional methods, with particular attention to adequate anesthesia and akinesia, and measures for obtaining ocular hypotony. A fornix based 3 m.m. conjunctival flap is made using either the razor blade knife or scissors. The conjunctiva is cut at its corneal epithelial junction; any bleeding is controlled by minimum point electro-cautery (thermosector unit). The larger vessels are point cauterized 2 to 3 m.m. posterior to the limbus such that there is minimal bleeding in the area of the incision. These and the following steps are simplified by the use of the 10x and 16x magnification of the Zeiss operating microscope.

The most adequate incision has been found to be the combined vertical-bevel type.[1] The measurements are well accepted and arrived at after consideration of the relations of the scleral and corneal triangles, the Canal of Schlemm, corneal stroma, Descemet's membrance, and the root of the iris to the incision in the limbal area. With a pointed caliper, 1 m.m. is measured posteriorly from the conjunctival-corneal epithelial juncture in the 12, 10, and 2 o'clock meridians. These points should be at the junction of opaque sclera and semi-translucent cornea.[2] This measurement would vary to be more scleral in cases of marked endothelial dystrophy, and more corneal with vascular irises, or a bleeding problem from blood dyscrasis or anticoagulants. A razor blade holder (Castroviejo) with a piece of cracked blade fixed so that 0.5 m.m. of the sharp tip protrudes beyond its end is used to make the vertical portion of the incision. Holding the instrument at 90 degrees to the limbus, an incision is made from the 10 o'clock to the 2 o'clock meridians in an even, continuous manner, at the site previously measured.[3] The incision should be continued from the 10 o'clock and 2 o'clock points to the 180° meridian at the junction of the opaque sclera and semi-translucent cornea. The anterior chamber is entered with the razor blade knife, in the groove, at the 10 o'clock meridian. The beveled portion of the incision is enlarged with the Castroviejo corneo-scleral scissors, held flat, to the 2 o'clock meridian. Minimal pressure and contact with the iris should be made as it can be noted, in some cases, pigment escapes into the aqueous which may contribute to postoperative iritis.

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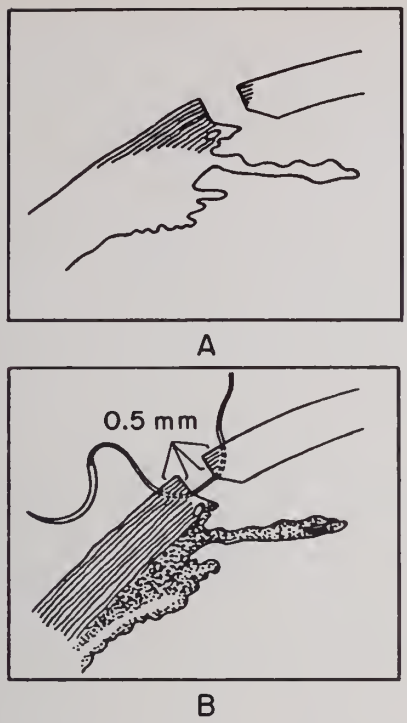


FIG. 1

A. The vertical-bevel type incision, the vertical portion through sclera and the beveled portion extending to the region of Schwalbe's line.

B. Measurements of course of suture through the middle third of cornea and sclera.

A suture needle, (7-0 or 8-0 Ethicon) is placed at 12 o'clock, in the manner described by Kirby[4], using the fine toothed forceps of Castroviejo or Bonn to grasp the outer edge of the cornea. The needle is made to enter 0.5 m.m. from the cut edge and carried through to emerge in the middle 1/3 of the corneal thickness protruding about 3 m.m., and placed radially. The cornea is released and allowed to settle back, free to assume its natural position of apposition. It is seen that the sclera can be picked up a its cut edge exactly beside the needle marking the point of accurate apposition. The point of the needle is then put through the scleral edge in the middle 1/3 of its thickness at this point of apposition and is to emerge 0.5 m.m. posteriorly.

The beveled portion of the incision is completed to the 180° meridian nasally and temporally with the Castroviejo corneo-scleral scissors, blades held flat. The incisional scissors cuts should be relatively long and even, rather than short and chopped. Pre-extraction safety sutures are placed radially at 10 and 2 o'clock, by the method shown in the illustrations. It is important that the forceps grasp of the corneal edge is released after the needle emerges 1 to 2 m.m. through the middle 1/3 of the corneal thickness. The middle 1/3 of scleral border is then picked up with the needle point, the shaft of the needle still being held by the needle holder. The scleral edge is grasped adjacent to this point with the Bonn, or fine toothed Castroviejo forceps, and the needle carried through the sclera to emerge 0.5 m.m. posteriorly. The same maneuver to check apposition is of value with these suture placements.

After lens extraction, the 12 o'clock suture is tied firmly with slight pull upward. This, and alternate traction on the suture strands, guarantees clearing iris while tightening the first 3 loop portion of the knot at the same time.[5] There should be no tension lines visible in the cornea to the suture, and usually the natural curvature of the cornea is maintained. Two opposite double loops complete the tie. The suture is cut 2 m.m. from the knot.

Miochol (acetylcholine) is injected to constrict the iris away from the incision.

The sutures at 10 and 2 o'clock are tied in the same manner.

At this point the anterior chamber is inspected with the 10x and 16x or higher magnification. It will be noted that because of the pre-extraction suture placement technique there is precise apposition of the incisional edges, free of incarceration of extraneous material, tissue, vitreous strands, or iris.

By the method described, four post-extraction sutures are placed radially, equidistant between the pre-extraction sutures and the extent of the incision. Additional sutures can be placed if inspection shows need for them. Any difficulties with managing the sutures because of the microscopic field can be avoided, if after the needle has been drawn through both cornea and sclera, the suture is held with the left thumb and forefinger just back of the needle and pulled through until about 2 cms. from its end. The suture can then be easily tied with the needle holder in the right hand. Also, the feel of the degree of tightness brought on the tie can be appreciated. The entire procedure is done using the 10x and 16x magnification of the operating microscope to note uniformity of degree of corneal tissue tension, accuracy of apposition, and position of iris.

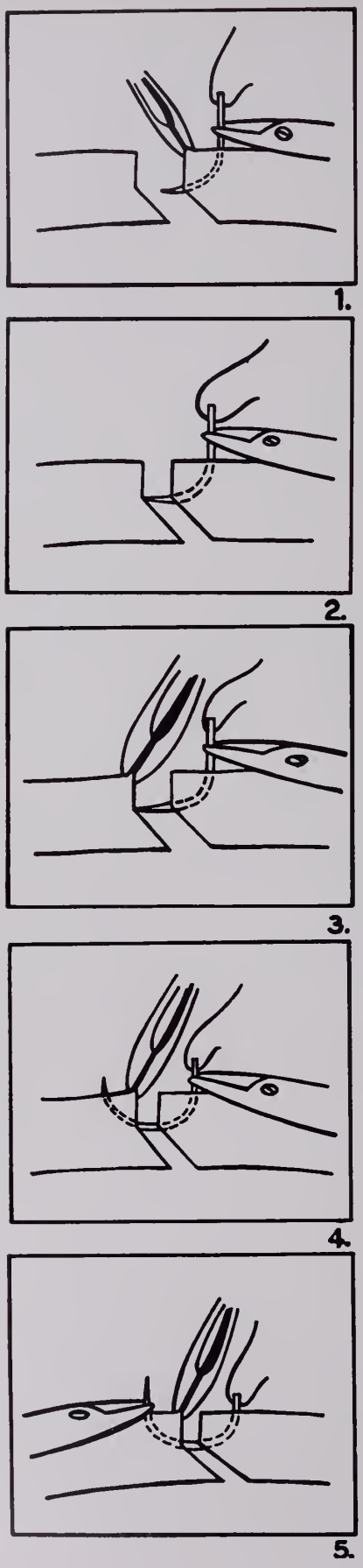


FIG. 2 (at left)

Five steps of the needle placement technique. 1. Forceps on corneal edge with needle point through middle third of cornea. 2. Needle point engages middle third of sclera. 3. Forceps on sclera edge. 4. Needle through sclera. 5. Needle carried through with needle holder, forceps hold on sclera maintained.

After completion of the post-extraction sutures, and management of the anterior chamber as preferred by the surgeon, the conjunctival flap is brought over the suture line and fixed with 6-0 plain cat-gut at 9 and 3 o'clock.

Comment

The sequence of the placement of the sutures allows more accuracy and ease in making the vertical and beveled portions of the incision. With the procedures now available for obtaining ocular hypotony, adequate anesthesia and akinesia, the greater detail and finer control of the needle placement makes this sequence safe and easier.

The sutures must be passed through the middle third of the corneo-scleral thickness. If too superficial, posterior gaping of the wound results. Aqueous infiltrates the corneal stroma, and healing is delayed. A wound leak along the suture or iris incarceration may result. The suture may even cut out of the tissue.

More frequently the sutures are placed too deeply. The suture may penetrate the anterior chamber, or result in penetration later due to necrosis of the thin deep layers. The tissues become strangulated by the deep suture from edema and necrosis results. Excessive vascularization between the wound edges may take place, further weakening wound healing.[6]

Seven corneoscleral sutures are used as seem necessary after inspection with the 16x to 25x magnification, even if the incision is air and water tight with a lesser number. With the use of 7-0 or 8-0 silk sutures this increased number does not lend to necrosis of tissue due to the proximity of the sutures.

Since the adoption of this technique, in over 100 consecutive cases, there has been no case of flat anterior chamber, iris prolapse, cyst formation at the incision site, wound dihiescence, or other complication relating to the healing of the incision. In two cases there was a slightly peaked pupil in the horizontal meridian which was attributed to a fault in suture tying. This was early in the series and Miochol was not available. It is possible that with its

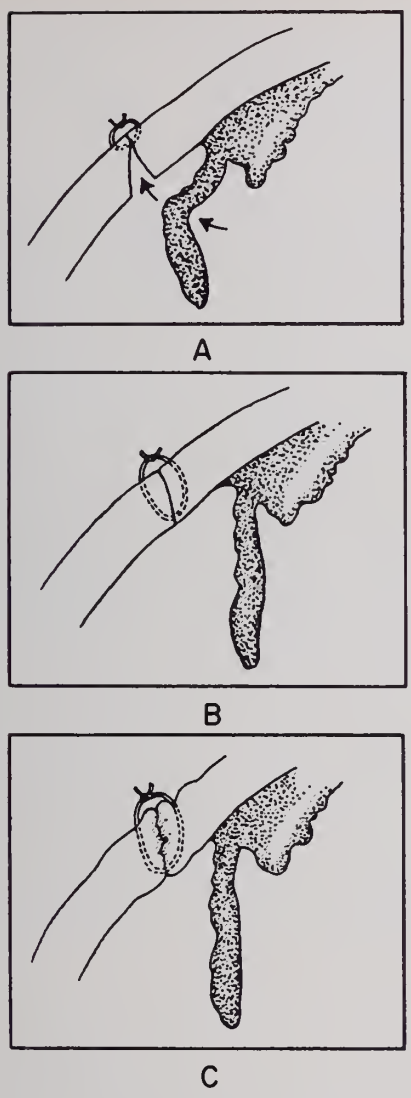


FIG. 3

A. Suture too superficial allowing posterior gaping of wound, aqueous infiltration of corneal stroma, iris incarceration.

B. Suture too deep, may penetrate anterior chamber or allow wound leak.

C. Suture too deep and tight resulting in strangulation of tissue from edema.

use, this tucking of the iris, or vitreous strand, in the posterior border of the incision could have been avoided.

One frequent criticism, the lack of maneuverability of the microscope, did not prove a problem after repeated practice with the procedure.

The exact accuracy of instrument and tissue control in making the incision and the placement of the sutures under the increased magnification is very satisfying. It is certainly recommended to obtain a higher degree of accuracy and minimal surgical trauma.

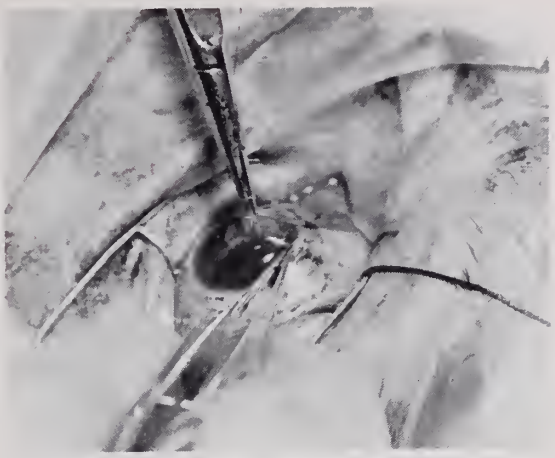


FIG. 4—MICROSURGERY: NEEDLE PLACEMENT

The operating microscope enables the surgeon to control the needle placement in closure of the cataract incision within 0.2 m.m.

Photograph shows Castroviejo 0.3 m.m. tooth forceps on corneal edge, needle point emerging through middle third of corneal thickness, using the 10x magnification of the operating microscope.

(Patient of Herbert P. Hargett, M.D.; photography by Norris E. Mode, P.P.A.I

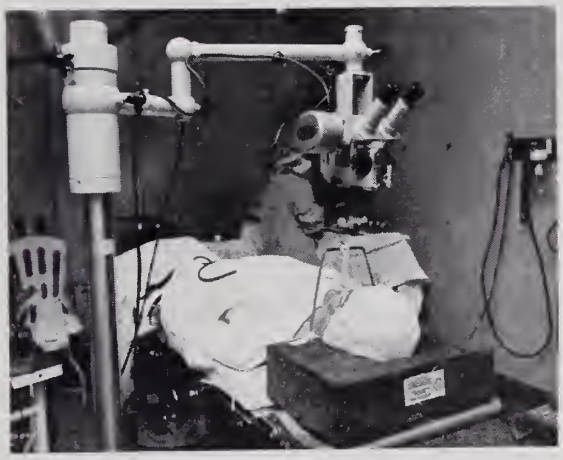


FIG. 5. Standard O.R. set up with operating microscope, head rest, oxygen catheter fixed on drape support.

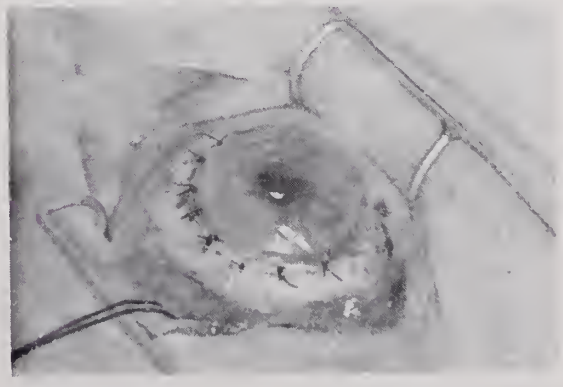


FIG. 6. Incision completely sutured. Pupil is constricted and round by acetylcholine.

(Continued on page 1139)

Airless Paint Gun Injuries of the Hand

PAUL M. WEEKS, M.D.*

Lexington, Kentucky

Airless paint gun injuries constitute a surgical emergency. Tissue destruction results from direct action of the chemical on the tissue and ischemia secondary to edema formation. Treatment demands removal of the chemical and prophylactic decompression of the involved part.

INDUSTRIAL progress has significantly advanced painting techniques. The modern commercial painter, using a four inch brush, can apply ¼-½ pint of paint per minute. Recent utilization of the hydraulic pump to force paint through a small bore nozzle—the airless gun—permits routine spraying of ten pints per minute. This phenomenal delivery is accomplished by introducing compressed air—up to 125 psi—into a hydraulic pump system which augments the paint hydrostatic pressure of paint 26 to 40 times. Thus, an airless gun, utilizing compressed air at 125 psi, can deliver paint under pressures of 3250 to 5000 psi.

The airless gun, *per se,* permits: 1) on-off control of paint release and, 2) pre-determination of spray pattern size. The nozzle of the airless gun has a bore of 0.031 inch (Fig. 1A). Attached over the nozzle is a spray cap secured by a retainer (Fig. 1B). The opening in the spray cap can vary from 0.007 to 0.040 inches and is drilled at an angle to allow various widths of spray patterns. The extremely high pressures at the spray cap are rapidly dissipated by atomization of the paint. At 12-15 inches, the spray of paint is harmless when the spray cap is utilized. However, if the spray cap is removed, the airless gun can be used to spray girders 20 feet high!

Only recently have reports of paint gun injuries appeared.[1-6] This case is reported to emphasize: 1) the initial rather insignificant appearance of the injury; 2) the actual severity of the injury; and 3) the methods of management.

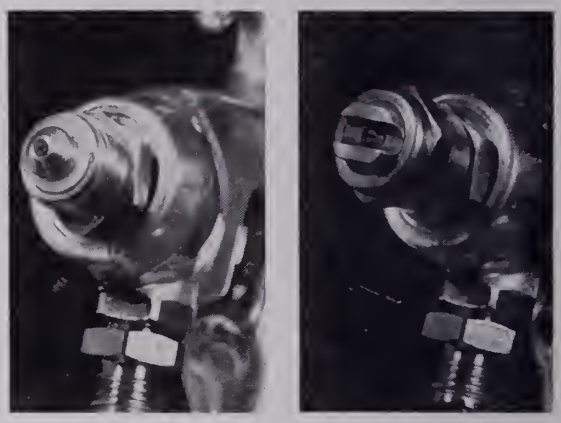


FIG. 1A The nozzle of the airless gun emits paint under 3000-5000 lb. sq. in. pressure through a 0.054 inches opening.

FIG. 1B Spray caps with various bores can be attached over the nozzle to regulate the spray pattern. No cases are reported with spray cap in place and the hand at least two inches from gun.

Case Report

A 53 year old white male was cleaning an airless paint gun by spraying paint thinner through it. The air compressor was operating at 90 psi (rendering a nozzle pressure of 2700 psi). To remove a tight spray cap retainer, the gun was held in the left hand and a small wrench, encircling the spray cap retainer, was being manipulated with the right hand. As his grip tightened, the trigger was depressed. The right index ray, resting snugly against the spray cap, received a momentary burst of paint and thinner which entered the skin through a small puncture wound. The hand was not painful initially but within an hour had become excruciatingly painful.

He presented at the University Hospital emergency room two hours after the accident. The hand was moderately swollen. The point of entry was a one mm hole on the radial side of the index ray at the base of the proximal phalanx (Fig. 2). The index ray was anesthetic and pale in color. The remaining rays were pink. X-rays of the hand revealed a small sub-

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FIG. 2 The small entry point appears insignificant.



FIG. 3 X-rays are of value when lead based paints were injected. Note small entry point and subcutaneous localization of paint. Paint thinner is radiolucent.

cutaneous collection of paint at the point of entry (Fig. 3).

At the initial operation, performed after an axillary block, the index ray was opened through a midlateral incision extending through the point of entry and continuing into the palm. After evacuation of the paint, the wound was thoroughly irrigated. Kerosene thinner was irrigated from the palm. Decompression of the neurovascular bundles to the index and long rays was gained by opening the overlying palmar fascia. The remaining rays did not appear to require decompression.

Twelve hours post-operatively, all rays were blue and exhibited marked delay of capillary filling. The rays were anesthetic over the median nerve distribution. Sensation over the ulnar digital nerves was intact. The patient was returned to the operating room immediately.

The second operative procedure was complicated by marked tissue edema and friability. The signs and symptoms of median nerve compression required division of the transverse carpal ligament. The median nerve was pale and exhibited a depression beneath the volar carpal ligament. The superficial vascular arch in the palm was completely exposed by excision of the overlying palmar fascia. The index digital vessels were thrombosed at their origin from the superficial arch. Each ray was decompressed through a midlateral line incision which gaped open immediately. Digital arterial blood flow improved but digital venous return was inadequate. This necessitated a second incision into the markedly edematous dorsum of the hand. Kerosene was irrigated from the base of the dorsal wound. This incision, by decompressing the dorsal veins of the hand, markedly improved digital venous return. After copious saline irrigation of the wounds, a loose hand dressing was applied.

Post-operatively the venous return of the rays, particularly the long, varied markedly from day to day. The rays have remained anesthetic over the median nerve distribution. The ulnar nerve is intact. At the first dressing



FIG. 4A The index ray has been decompressed through a midlateral line incision extended through the point of entry and continued into the palm to permit decompression of the digital vasculature.



FIG. 4B The hand, four days post injury, is markedly swollen. The intense and extensive inflammatory reaction resulted in a markedly swollen hand four days post injury.

change (four days after injury) the hand was markedly swollen (Fig. 4). Necrotic fat, pus and kerosene were expressed through all incisions. Subsequently the index digit required amputation. The hand healed slowly. Five months later full digital extension and digital flexion to within 1 cm of the palm were possible. Digital median nerve sensation returned.

Discussion

The usual components of materials most often sprayed through an airless gun are listed in Table I. The alcohols, turpentines and mineral spirits are prominent components. The thinner injected in our case contained kerosene. The median neuropathy probably resulted from thrombosis of nutrient vessels to the nerves. Sensory and motor recovery in such a case has been reported by Boyes et al.[4]

Turpentine and mineral spirits are utilized for experimental production of abscesses. Ross et al, injected turpentine subcutaneously into guinea pigs. This evoked an intense and extensive inflammatory reaction, particularly around vessels. These vessels eventually became thrombosed. Necrosis of fat, muscle and skin were observed. The reparative processes were prominent within five days and the necrotic foci encapsulated by eight days. The studies were not extended beyond eight days to determine experimentally if residual fibrosis from such injury is minimal or non-existent as noted clinically by Boyes et al.[4]

Tissue destruction from injection of paint, thinners, etc. results from 1) direct chemical action of the agent on the tissue; and 2) ischemia secondary to edema formation. Treatment is directed at rapid and thorough removal of the offending agents and prevention of ischemia secondary to edema by adequate decompression of the vasculature.

Pre-operative determination of the manner of injection may be of value in determining the extent of injection, particularly a non-radiopaque material. In our case, reconstruction of the accident suggests that paint thinner could have been injected into the palm and dorsum of the hand. Since only a small amount of paint was left in the gun, the majority of injected material was radiolucent paint thinner. Accurate reconstruction of the accident would have necessitated exploration of the dorsum of the hand at the initial operation, preventing some of the later swelling and subsequent venous obstruction. The entry point at the midlateral line of the ray would indicate that thinner could be sprayed either onto the dorsum or palmar aspect of the hand. The type of the material and manner of injection is important in x-ray interpretation. If only a radiopaque paint is injected, x-ray would reveal the extent of injection and the degree of successful removal of the paint. If the injected material is not radiopaque, x-rays will be of little value.

Operative removal of the injected paint and/or thinner is accomplished by debridement of the entry point and pathway. Paint in the fat

TABLE I

PAINTS		LACQUERS
Titanium dioxide	10-25%	Nitrocellulose
Titanium calcium	10-35%	Ester gum
Inert filler pigments	10-20%	Cottonseed oil
Alkyd resin or oil varnish	9-20%	Pigments
Mineral spirits	25-35%	Nitric Acid
White Lead	5-20%	Magnesium Oxide
		Lead Acetate
LACQUER THINNERS		**VARNISHES & SHELLACS**
Ethyl alcohol	0-5%	Resins
Ethyl acetate	20-21%	Methyl alcohol
Butyl alcohol	10-11%	Ethyl alcohol
Butyl acetate	20-23%	Gasoline
Toluene	25-28%	Benzene
Aliphatic hydrocarbons	16-20%	Turpentine
		Lead
		Sodium hydroxide

beyond the distal palmar crease is best removed by excision of the fat. Copious irrigation aids removal of any foreign material not fixed to the tissues.

Decompression of the swollen hand is primarily directed at relief of venous obstruction since less tissue pressure is required to obstruct the venous system. The venous drainage of the hand and rays is accomplished through two major systems: 1) superficial system—the basilic and cephalic veins extending from the dorsum of the hand to the antecubital fossa; and 2) deep system—small digital veins drain into palmar superficial and deep arches and thence into the veins accompanying the radial and ulnar arteries. The majority of venous drainage is over the dorsum of the hand. However, it is evident from experience with traumatic avulsions of the entire dorsum of the hand and wrist (to include all dorsal venous drainage) that the deep system through the palm can provide adequate drainage from the rays. Cyanotic rays indicate compromise of both venous systems.

Decompression may be required in a ray, the palm or the dorsum of the hand. A ray can be decompressed through a midlateral line incision. Subcutaneously, on the volar aspect of the incision, fascia is noted extending from the skin to the bone. This fascial attachment is responsible, in part, for fixation of skin. The fascia delineates a volar compartment which contains both neurovascular bundles and the tendon sheath. To decompress this volar compartment, the fascial attachment between the skin and the bone must be divided. Decompression of the palmar vessels requires opening each tunnel formed by the palmar fascia and its vertical projections to the metacarpals. Opening the "roofs" of these tunnels is adequate for decompression. Decompression of the dorsum of the hand requires only incision in the skin.

How extensive a decompression should be attempted? If involvement is limited to a ray, it should be decompressed through a midlateral line incision. If paint is in the palm, each digital vessel should be decompressed by opening the palmar fascia. If paint is in the dorsum of the hand, then a dorsal incision is necessary. Anytime the digits have inadequate venous return, one must assure decompression of the superficial and/or deep venous systems. If one venous system is thrombosed then the other system must be decompressed.

Reports prior to June, 1967, revealed that paint gun injection of a ray uniformly resulted in amputation of the ray. These included cases reported by Workman (1963), Blue and Direstine (1965), Nahajian (1966), Morley (1967) and Ross et al (1967). Boyes' (1967) report of 14 cases provided the most encouraging results. Six cases with injury limited to a ray resulted in amputation of the involved ray when removal of paint and decompression was delayed. In six similar cases, which underwent immediate removal of the paint and decompression of the ray, skin loss was limited and good functional results were obtained. Two cases sustained extensive injection of paint into the palm. These were treated with early removal of paint and extensive decompression which obtained excellent functional results. The authors concluded that if the viability of the ray can be preserved, the chance of functional recovery without fibrosis is excellent.

Summary

Perforation of the skin by paint or related products sprayed from an airless paint gun constitutes a surgical emergency. Tissue destruction from injection of paint, thinners, etc. results from 1) direct chemical action of the agent on the tissue; and 2) ischemia secondary to edema formation. Treatment is directed at rapid and thorough removal of the offending agents and prevention of ischemia secondary to edema by adequate decompression of the vasculature.

If treatment is delayed, amputation is the rule. If treatment is immediate and adequate, functional recovery is to be expected.

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Reversed Colon Segment in an Infant with Massive Small Bowel Resection: A Case Report†

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After massive intestinal resection, vagotomy or an antiperistaltic small bowel segment will slow gastrointestinal transit time and improve nutrition. This is the first clinical report of the creation of an antiperistaltic colon segment.

MASSIVE resection of the small intestine and colon is accompanied by severe nutritional and electrolyte alterations due to the rapid transit of ingested nutriments and the decreased absorptive surface. In addition to fluid and electrolyte losses, there is an increase in stool fat and a variable but decreased absorption of protein and carbohydrate. The mortality rate following massive intestinal resection has been reported at 75% in infants[1] and over 90% in adults.[2]

Clinical and experimental studies indicate an improvement in both nutrition and survival rate following massive small bowel resection when a short segment of jejunum or ileum is reversed,[3,4,5,6] a loop of intestine is created[7] or vagotomy and pyloroplasty is performed.[8] There is a long term adaption of the residual intestine and colon by dilatation and mucosal hyperplasia which improves absorption and nutrition.[9,10,11] The present report records the first known experience with reversal of a colon segment following massive intestinal resection. Although the case ended fatally, there was a decrease in the frequency of stools and temporary improvement in the infant's nutrition.

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Case History

J. A., a 3 week old white male infant, was admitted to the University of Kentucky Hospital because of lethargy and dyspnea. Pregnancy and birth were uneventful, but one week prior to admission the patient developed omphalitis. Forty-eight hours before admission, he became lethargic, regurgitated his feedings, and developed labored respirations. Temperature was 97.8 degrees; pulse, 200; respiration, 120; and weight, 3700 grams. The abdomen was distended, bowel sounds were hypoactive, and rectal examination showed dark blood in the stool. Hemoglobin was 13.8 gms., hematocrit 40.5%, WBC 19,700, BUN 60 Mg.%, sodium 144 Meq., potassium 6.9 Meq., CO_2 3 Meq., chloride 103 Meq., and glucose 30 Mg.%. Abdominal x-rays indicated decreased intestinal gas.

The admission diagnosis was shigella gastroenteritis. He was treated with intravenous fluids, sodium bicarbonate, digoxin, amphicillin, streptomycin, and neomycin. Twenty-four hours after admission the patient's weight was 3900 grams and he appeared improved. A repeat x-ray again showed decreased gas in the small intestine and increased space between loops of small bowel. Forty-eight hours after admission surgical consultation was obtained and paracentesis revealed bloody peritoneal fluid. At laparotomy the small intestine was edematous and infarcted, with thrombosis of the portal and mesenteric veins. The small intestine was resected from a point 2.5 cm beyond the ligament of Treitz to the ileocecal junction. The cecum and the edematous stump of jejunum were exteriorized in an adjacent position so that subsequent Mikulicz anastomosis could be performed. Microscopic examination of the resected intestine revealed venous thrombosis and diffuse necrosis.

Recovery from operation was satisfactory, and the infant was maintained on intravenous

fluids, with replacement of nasogastric and jejunostomy losses. On the fourth post-operative day a Payr clamp was placed to a depth of 3 cm. across the septum between the exteriorized ends of bowel. Four days later the clamp had cut through the spur and was removed. Oral feedings were begun with glucose water and advanced to a formula. On the sixteenth post-operative day an extra-peritoneal closure of the jejunocecal anastomosis was performed. He averaged 7 liquid stools per day over the next 23 days. Various types of feedings, opiates and anticholinergics were tried without improvement. Thirty-nine days following the original operation, his weight had decreased to 2720 grams, and his clinical condition was deteriorating. Due to an inadequate length of residual jejenum from which to form a reversed segment, it was elected to reverse a segment of transverse colon despite the lack of clinical or experimental precedent. The original incision was reopened and the transverse colon was divided 1 cm. to the left of the middle colic artery. A five cm. segment of colon was isolated distal to the point of transection, reversed on its vascular pedicle, and reanastomosed with a single layer of 4-0 silk. The infant survived an additional 15 days during which time he averaged 3.1 stools per day. His weight increased from 2730 grams postoperative to 3120 grams on the ninth postoperative day, and then decreased to 2890 grams at the time he expired.

At autopsy the reversed segment was viable and the anastomoses were intact. There was a slight dilatation of the proximal colon, and elongation and hypertrophy of the residual jejunum to approximately three times its original length.

Discussion

In adults, the resection of the ileum may result in steatorrhea and vitamin B_{12} deficiency which can be controlled by a low fat diet (30-50 grams per day) and regular injections of vitamin B_{12}. Massive resection of the jejunum and ileum is followed by steatorrhea, decreased protein and carbohydrate absorption, hypokalemia, hypocalcemia, and deficiency of vitamin B_{12} and magnesium.[9,10] When the ileum is completely resected, the minimal residual length of jejunum necessary for absorption of water soluble nutrients is one to four feet.[11] Resection of most of the small intestine in infants has an even more profound effect because of the nutritional requirements for growth. Wilkinson[1] advocated the use of pre-digested milk or breast milk fortified with glucose and amino acids but noted little advantage to the use of opiates to reduce intestinal transit time. Failure of this infant to improve with special feedings forced consideration of an anti-peristaltic bowel segment to slow the transit time. The borderline vascular status of the short length of remaining jejunum led to reversal of a segment of colon even though clinical and experimental precedent for the procedure was lacking.

Following operation the stools decreased from an average of 7 to 3.1 per day. The gastrointestinal transit time measured on three occasions with indigo carmine was found to be 1) three hours and five minutes; 2) four hours; and 3) 18 hours. Unfortunately, transit time was not measured prior to colon reversal. The autopsy finding suggests that earlier reversal of the colon segment might have provided an opportunity for subsequent reversal of a jejunal segment.

Summary

This is a report of a three-week-old infant who underwent near-total resection of the jejunum and ileum. The infant's nutritional status showed progressive deterioration despite the use of special feedings, opiates, and anticholinergic drugs. On the 39th day after resection a five centimeter, anti-peristaltic segment of transverse colon was created in an effort to prolong intestinal transit time. This procedure was followed by a decreased frequency of stools and a temporary increase in weight. Although the infant subsequently expired, the results suggest that reversed colon segments may have value following massive intestinal resection.

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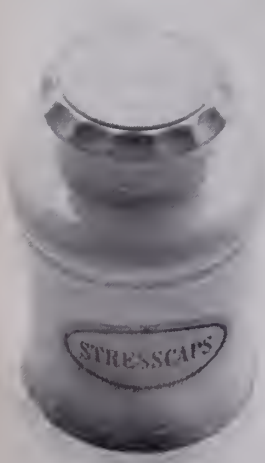
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(Continued on page 1140)



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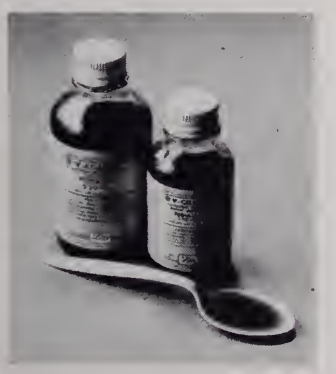
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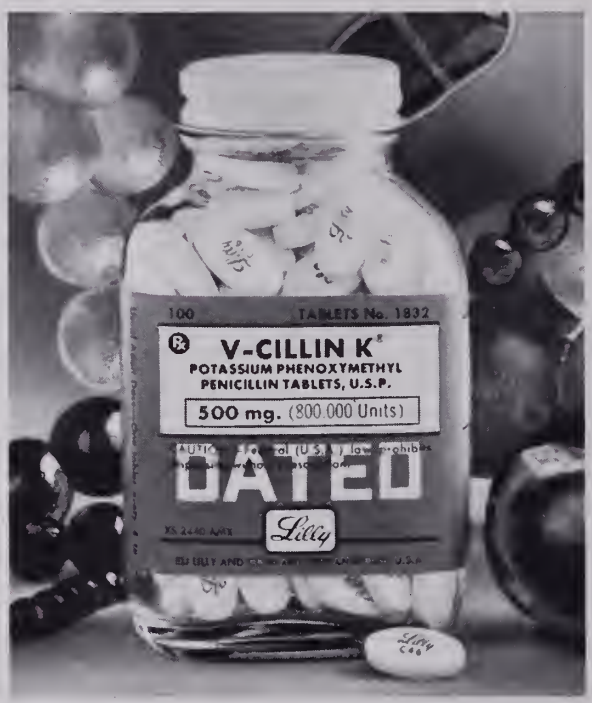
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See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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SPECIAL ARTICLES

Chiropractors and Patients in Kentucky†

Richard Park, B.S., Jesse W. Tapp, M.D., and
Donald L. Hochstrasser, Ph.D.*

THIS report covers work done during the summers of 1965 and 1966 to investigate and answer some basic questions about the practice of chiropractic in Kentucky. While statistical information is readily obtainable on other health professions, little has been published about the number and distribution of chiropractors in Kentucky or elsewhere. An extensive survey of chiropractic in California is the only comprehensive study available for a statewide comparison.[1] Furthermore, although data and discussion concerning certain educational, legal, and other aspects of chiropractic are available, there have been few scientific studies on chiropractors at work or on utilization patterns and descriptions of chiropractic patients.[2] The National Health Survey[3] (NHS) provides one survey of chiropractic utilization with some personal data on these patients. This paper summarizes findings on the pattern of chiropractic practice in Kentucky and the people who used chiropractic services in a Kentucky county.

Methods

The first part of the study, done in the summer of 1965, was designed to establish the number, distribution, and characteristics of licensed chiropractors in Kentucky. Statistical and other information available for this purpose was gathered and analyzed. Forty practitioners chosen at random from the total group of chiropractors in the state were visited and interviewed to validate these data. Visits also were made to another 50 randomly selected chiropractic offices for additional information on the professional background and work of a cross-section of chiropractors throughout the state. Sources such as the offices of vital statistics and radiation control of the State Healh Department and the secretary of the Chiropractic Board of Examiners were consulted for information. The second part of the study was carried out in a central Kentucky county during the summer of 1966. Two cities in the county contain approximately one-half of the county's population of 14,000 persons. Resident in the county were four doctors of medicine and two chiropractors. Data were gathered by visiting a random sample of households and interviewing an informant to determine the number of people who had used any health practitioner in the preceding nine months. Personal characteristics were recorded for all household members and observations including family situation, economic background, and social class were made on each household. The informant was questioned about all people in the household who had used medical and chiropractic services, the nature of their ailments, and their reasons for choice of practitioner.

The Chiropractors

The Chiropractic Examining Board was established by state law (KRS 312.085) to examine, license, and register annually all chiropractors wishing to practice in Kentucky. Licensing requirements are a high school education, four years or 4,000 hours at a chiropractic school, and a passing grade on the chiropractic board examination. Also, a license may be obtained by reciprocity with many other states. The records of the Board showed that there were 486 chiropractors (36 female) licensed in 1965 who listed Kentucky as their place of residence. The secretary of the Board estimated that 65 to 70%, or about 365 of these chiropractors were engaged in active practice. Random sampling of counties throughout the state showed this to be an accurate estimate, and in the sampled areas, no unregistered chiropractors were found. The chiropractors in the sample were interviewed regarding their backgrounds and practices.[4] In 1962, there were 509 chiropractors registered and residing in Kentucky. Therefore, in the three-year period between 1962-65, there was a net decrease of 23 chiropractors registered and living in Kentucky. In addition, there were 1400 chiropractors residing in other states and licensed in Kentucky in 1965.

Figures I and II show the distribution of physicians and chiropractors in Kentucky. Chiropractors are sparsely distributed in eastern Kentucky compared to the rest of the state, whereas physicians are more widely available throughout the state. A comparison of the number of practitioners in Kentucky in 1965 with the California report for 1957 gives some per-

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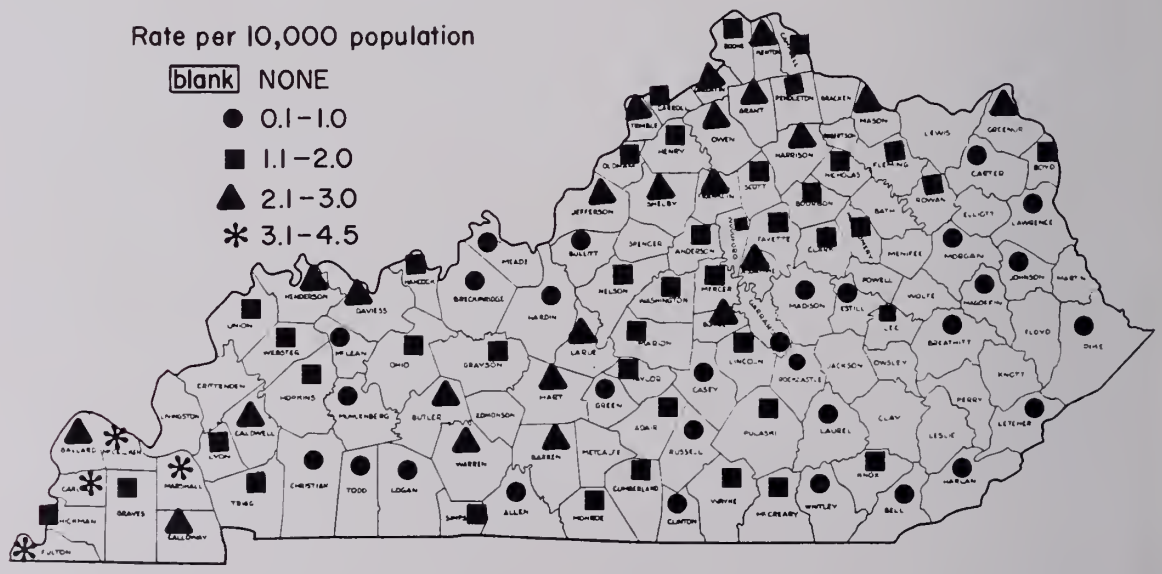
DISTRIBUTION OF DOCTORS OF MEDICINE IN KENTUCKY COUNTIES, 1966

FIGURE I

spective on the situation. The number of chiropractors per 10,000 population in Kentucky is higher, 1.6, than a national estimate, 1.3; however, only half the figure, 3.1, for California reported in 1957. In contrast, the number of physicians, 9.4 per 10,000 population in Kentucky in 1964, is markedly lower than for the nation, 14.6, or California, 14.9.

The Chiropractic Clientele

One hundred and fifty-four households were randomly selected by geographic location and visited in a central Kentucky county. This sample was found to be representative of the county population in terms of household size and the distribution by age and racial groups. Two hundred and ten of these people



DISTRIBUTION OF CHIROPRACTORS IN KENTUCKY COUNTIES, 1965

FIGURE II

(40%) were reported to have been seen as patients by a health practitioner between September 1, 1965 and June 30, 1966. One tenth of these patients saw a chiropractor, so it may be estimated that 4% of the total population of the county saw a chiropractor in that nine-month period. This finding is higher than the 2.3% utilization of chiropractors reported by the NHS[3] for the nation as a whole during the twelve-month period of 1964; however, it is close to the 4.3% utilization found for farm dwellers in that survey. The chiropractic patients were distributed among 11% of the households in this study. Moreover, at least one family member had seen a chiropractor at some time in the past in 31% of the households visited.

Characteristics of Patients

Seventy-six percent of the chiropractic patients were in the group 20-60 years of age with the highest proportion in the 40-59 years of age group. Only 9.5% of chiropractic patients were below 20 years of age. The NHS reported similarly that the highest proportion of population seeing chiropractors was in the 45-64 age group. Table I shows the utilization of chiropractors in contrast to the utilization of physicians by age groups. Note that the utilization of physicians is remarkably similar in all age groups in comparison to the predominantly middle-aged chiropractic clientele. Only two children had been seen by chiropractors and they had been to physicians also, as had six older patients reporting chiropractic visits.

Although more women (117) than men (93) went to a doctor of medicine or chiropractor during this period, there was a slightly higher proportion of men patients visiting chiropractors (11 men to 10 women). The NHS also found a higher proportion of men going to chiropractors, as well as a higher proportion of white versus non-white chiropractic patients. This survey found the same racial trend, but the number of non-white patients was too small for statistical significance. The highest rates of chiropractic utilization in this study were in the upper and middle class groups of the county. Geographically, the highest rate was in the rural area.

Reasons Why Patients Use Chiropractic

Most of the patients who visited a chiropractor considered him a type of health specialist and sought his help because of this belief. The most common type of disorder for which chiropractic help was considered useful was musculo-skeletal. Respiratory, gastrointestinal and headache problems also were mentioned. There was no general animosity elicited in the household interviews toward medical practitioners and most respondents believed that a physician has more overall training and expertise than a chiropractor. However, there was a feeling that a chiropractor has more specialized training for musculo-skeletal, back and joint problems. Several respondents in this study considered the chiropractor a family practitioner whom they consulted regardless of their problem. They believed he was as capable as a doctor of medicine and had the advantage of being readily available to make house calls, take X-rays, or offer consultation. Only 14% of the chiropractic patients reported their condition as disabling enough to miss school or work. The period of disability ranged from one to four days. In contrast, 73% of the patients seen by medical doctors reported their condition disabling enough to miss school or work.

Chiropractic in the Community

When asked if they would go to a chiropractor if the need arose, 25% of all the household respondents said yes. It is noteworthy that these individuals fell mostly in the middle and upper class households. On the other hand, 29% of the people interviewed stated they definitely would not go to a chiropractor under any circumstances. The remainder of the respondents, almost half of the group (46%), were either undecided or did not know what a chiropractor is. Included in the latter group were many in the lower socio-economic class.

Various ideas are prevalent regarding the successful persistence of chiropractic in the face of dramatic advances in medicine and the lack of scientific evidence to support the practice of chiropractic. These notions fall more or less into two general categories. On the

TABLE I

Age Distribution of Patients and Utilization Rate for Physicians and Chiropractors in a Sample of a Kentucky County, September 1, 1965 to June 30, 1966

Age	Household Sample Population	Patients Visited Chiropractors Only	Patients Visited Chiropractors and Medical Doctors	Total Patients Visited Chiropractors	Chiropractor Utilization Rate*	Total Patients Visited Medical Doctors	Medical Doctor Utiliza.**
0-4	57	0	1	1	1.8	22	38.6
5-9	60	0	1	1	1.7	19	31.6
10-19	87	0	0	0	0.0	29	33.3
20-29	76	2	0	2	2.6	29	38.2
30-39	64	1	1	2	3.1	24	37.5
40-49	49	4	2	6	12.2	21	42.8
50-59	63	3	3	6	9.5	28	44.4
60+	69	3	0	3	4.3	24	34.8
Unknown	1	0	0	0	---	1	----
All Ages	526	13	8	21	3.9	197	37.5

*Percent of Total Sample Population
**Includes eight who also visited chiropractors

one hand, there is the view that chiropractic is out-and-out quackery rendering nothing but an incidental type of psychological benefit to patients. The advocates of this position claim chiropractic is able to maintain itself only through a cruel and dishonest exploitation of the ignorant and gullible. However, an opposite view holds that chiropractic is capable of being a bona fide profession with something more than merely psychological benefits to offer patients. Those who hold this belief argue that chiropractic is able to sustain itself because it actually does provide an effective type of health service to certain patients.

The pros and cons surrounding these two conflicting interpretations of the persistence of chiropractic continue to be discussed and debated at great length. Regardless of the ultimate results of this argument, it is quite clear that the objective merits of chiropractic do not provide a full explanation of its continuance in the community. Indeed, equally as important as the biological and technical aspects of chiropractic are the social and human conditions surrounding its practice and use. Particularly prominent in this regard are the individual and family experiences which patients have had with chiropractic and the kind of image and support it has in the society at large.

Undoubtedly, many patients with functional complaints feel better after the personal and manipulative attention of a chiropractor. Furthermore, it appears that some patients suffering from chronic or obscure complaints turn to chiropractors after failing to secure the type of relief they expected from doctors of medicine, although in this study only one or two such cases were identified. There also is evidence that many individuals and families consider chiropractors genuine and competent health practitioners to be consulted for a variety of ills, especially those of the musculo-skeletal system, like the 25% of households in this study. Moreover, the chiropractic patients themselves are often drawn predominantly from the middle and upper classes. Hence, though small in number, they nevertheless can be expected to lend considerable economic support to chiropractic. They also are in a position to exert substantial social and political influence in its favor at many levels throughout society. In addition, there is an undecided segment (as in this study) in the population who may know very little about chiropractic education or training. Utilization of chiropractors by this group may vary from area to area depending on local advertisements, hearsay from friends or family, or general acceptance. This group is susceptible to being influenced one way or the other by public information to use or not use chiropractic.

All in all, then, it would seem that as long as these socio-cultural conditions continue on a widespread basis, the practice and practitioners of chiropractic will continue in Kentucky and other areas of the nation.

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EDITORIALS

The New President

IN SEPTEMBER, George F. Brockman, M.D., became the 118th president of the Kentucky Medical Association. He has served on many KMA committees in recent years, most recently as chairman of the Building Committee and of the Advisory Committee to the Editor of the Journal. He was KMA delegate to the AMA in 1961 and was speaker of the KMA House of Delegates in 1965.

Born in Louisville, Doctor Brockman attended DuPont Manual High School, then entered the University of Louisville and graduated from the School of Medicine in 1935. He interned at the Louisville General Hospital and followed this by periods of association with Hazelwood Sanitorium and the Kentucky State Department of Health. He earned his M.S. degree at the University of Kentucky in 1939. He became a commissioned officer in the U.S. Public Health Service but requested military duty and served in the Aleutians and North Pacific during World War II. After the war he was associated with the State Department of Health for awhile and then went to Cook County Hospital, Chicago, for training in radiology.

Since entering private practice in Greenville, the new president has been active in medical and civic affairs. He and Gaithel L. Simpson, M.D., established the Greenville Cancer Clinic which was the first American Cancer Society Clinic in a rural area. He was a founder of both the Greenville Industrial Development Foundation and the Muhlenberg County Chamber of Commerce. These have only been some of his civic interests. He spent two months in South Viet Nam in 1965, helping to initiate the AMA program for medical care in that country and returned there for another two months in 1966.

In spite of his many organizational and civic activities the new president's primary medical interests are in the laboratory and he has been particularly interested in the electrical activity of the heart. When he gets away from medicine entirely, he enjoys water skiing and photography which are hobbies his wife shares with him.

The new president of the Kentucky Medical Association brings with him certain personal characteristics which the Association is certain to benefit from. Among these characteristics are a wide range of interests, energetic commitment, humility and not the least, a keen sense of humor.

WALTER S. COE, M.D.

Unity for Legislation

WITH the next session of the General Assembly only eight weeks away, it is timely to concern ourselves with both desirable and undesirable legislation. Whether one wishes to have favorable legislation passed or undesirable bills defeated, good rapport with our respective representatives and senators is a must. To contact our legislator only when we wish something passed or defeated is not enough — and it shouldn't be enough. To be able to effectively and frankly express your views to your legislator, you must *know* him. For him to consider and heavily weigh your views, he must know *you.*

Thus it becomes our responsibility to initiate visits with our elected legislators in our homes, offices or social circles so that we many know and understand one another. This should be the responsibility of *all,* because a legislator is responsible to all his constituency, not just a few. The Committee on Legislative Activities will exert every effort to convey the views of free medicine to our legislators, but indeed the interest of "back home" physicians is para-

mount for success. I hope that *you* will see that you know your legislator and that he knows you prior to the next session of the General Assembly. (I also hope you worked for and made contribution to the candidate of your choice).

If any individual physician or specialty group desires to have legislation introduced, it would behoove all concerned to first channel this proposal through the Committee on Legislative Activities. This would serve many purposes:

1. Our Committee would be aware at all times of pending legislation introduced or supported by our profession;

2. It would make it possible for our Committee to appoint a study committee to review and research the proposed legislation to work out any possible amendments which would, in the end, strengthen the proposed legislation; and

3. It would permit consideration by KMA and, if approved, present united support thereby enhancing the possibility of its passage.

Practical politics makes it impossible to successfully support a large number of bills. Therefore, we must exercise good judgment in selecting those proposals most important to us and to the general public.

It should be clearly understood that the Committee on Legislative Activities cannot and will not officially support any proposal, regardless of its merit, unless it has first been acted upon by this Committee and approved by the KMA Board of Trustees.

FRED C. RAINEY, M.D.
Chairman, State Affairs
KMA Committee on Legislative Activities

Without Apology

DURING the past generation the American Medical Association has had a number of outstanding physicians who were also medical statesmen elected to the presidency. These men have consistently guided the affairs of American medicine in a constructive and progressive manner. The opinion has been expressed during the past year that the progress towards regimentation of our profession could have been prevented by proper leadership 30 years ago. It would be most difficult to substantiate such a claim. On the contrary we feel that the enlightened and progressive leadership we had at that time very probably prevented the complete socialization of medicine which was a real threat before and after World War II.

The last 10 years have given us a series of presidents of the AMA who have been men of great stature and who have continued the tradition of medical statesmanship in the same pattern set by their distinguished predecessors. We have a special reason to be confident in the enlightened leadership of Milford Rouse, M.D., the present occupant of that office, a gifted and cultured gentleman who has been engaged in the private practice of medicine and in part-time teaching in one of our leading medical schools. He is well acquainted with the viewpoint of the cross section of physicians in practice today.

Citizens of Texas have bestowed upon him every honor that is within their right, both professionally and in respect to civic service. His experience in leadership includes presidency of the Texas Medical Association, chairmanship of the Board of Councilors of the Southern Medical Association, presidency of SMA and Speaker of the House of the AMA before he was elected to the presidency. His record of soundness and achievement is beyond fair criticism.

Dwight L. Wilbur, M.D., president-elect, has behind him a similar record of distinguished service. He has for many years been the editor of the California Medical Journal, has been president of the American Gastroenterological Association and the American College of Physicians to mention only a few of his accomplishments. It is true that the ideology of these two men differs somewhat, but it is only an honest approach to the same goal, the improvement of American medicine and maintaining its control safely in the hands of the physicians who render the service.

During the past generation three distinguished Kentuckians have been president of the AMA; Irvin Abell, M.D., Elmer Henderson, M.D., and Fred Rankin, M.D. We are at present well represented in the National Councils with Robert C. Long, M.D., as trustee and our own list of delegates: J. Thomas Giannini,

M.D., Louisville; John C. Quertermous, M.D., Murray; Charles C. Rutledge, M.D., Hazard, and alternate delegates: Charles G. Bryant, M.D., Louisville; William W. Hall, M.D., Owensboro; David B. Stevens, M.D., Lexington. We cannot ask for better leadership. Cooperation and team work of the component units of the AMA in achieving our goal of excellence in medical care with a minimum of government regimentation can only be accomplished by united and continuous effort.

There has been much ado in recent years about the image of the physician and it has generally been derogatory of the place that we occupy in the public mind today. We bewail the passing of the country doctor, the family physician, the wise councilor and the unhurried priestly manner of the bedside physician. In this connection it may be encouraging to call attention to a quotation from Henry Gibbons, M.D., taken from an introductory lecture on medicine delivered by him in 1849, the year of the first annual meeting of AMA. Doctor Gibbons was a very distinguished physician of his day. He was a graduate of the University of Pennsylvania, practiced medicine in Philadelphia and later moved to San Francisco where he was instrumental in organizing the California Medical Society and served as its president from 1857-1871. He was also a teacher in the medical department of the University of the Pacific and a medical editor.

We are indebted to Donald C. Geist, M.D., editor of Philadelphia Medicine, and to Samuel X. Radbill, M.D., the author of the following editorial which appeared in the issue of November 28, 1964. Doctor Gibbons said:

> "It may be well to devote a few minutes to the inquiry, whether the progress and improvement of medical science are appreciated by the public mind. Does the medical profession stand higher now than in times past, when its claims were far inferior? Is it gaining on the confidence and affections of the people, in proportion as it accumulates the means of accomplishing its holy mission?
>
> The answer to these enquiries is in no degree flattering to professional pride. It cannot be denied that the ancient glories of our craft are departed—that its palmy days are ambered with the past. The solemn and magisterial air, and the huge wigs of our illustrious predecessors, though backed by a gold-headed cane and a precious roll of parchment 'To all men greeting,' no longer attract the homage of the crowd to the deified Priest of Esculapius. Old things are done away and all things become new. Unhallowed hands have stripped the ancient idol of all mysterious adornment—all factitious covering, and exposed it to the microscopic eyes of an irreverent and scrutinizing generation.
>
> I repeat, our profession has declined in public estimation within the present century, whilst it has been advancing in its claims and merits beyond all precedent. Mankind appear to have but little more respect for it now than in the days when medical science was but a jumble of superstition and empiricism, and when its practitioners were banished from Rome as public pests. To make such an acknowledgment is disagreeable; but if the contemplation of the picture should lead to an effort to correct the evil and bring about a better state of things, the confession may prove salutory."

It would appear that physicians have for a long time been concerned about their "image." It is just barely possible that if we spend our time and energy in dispensing medical care to the very best of our ability and less time worrying about our image and our public relations, both the American public and we might be better off.

SAM A. OVERSTREET, M.D.

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Acute Superficial Thrombophlebitis: Initial: 6 capsules or tablets daily in divided doses for 2 or 3 days. Maintenance: 3 capsules or tablets daily. Usual duration of therapy is 5 to 7 days (rarely beyond 10 days). 6509-V(B)R2

*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

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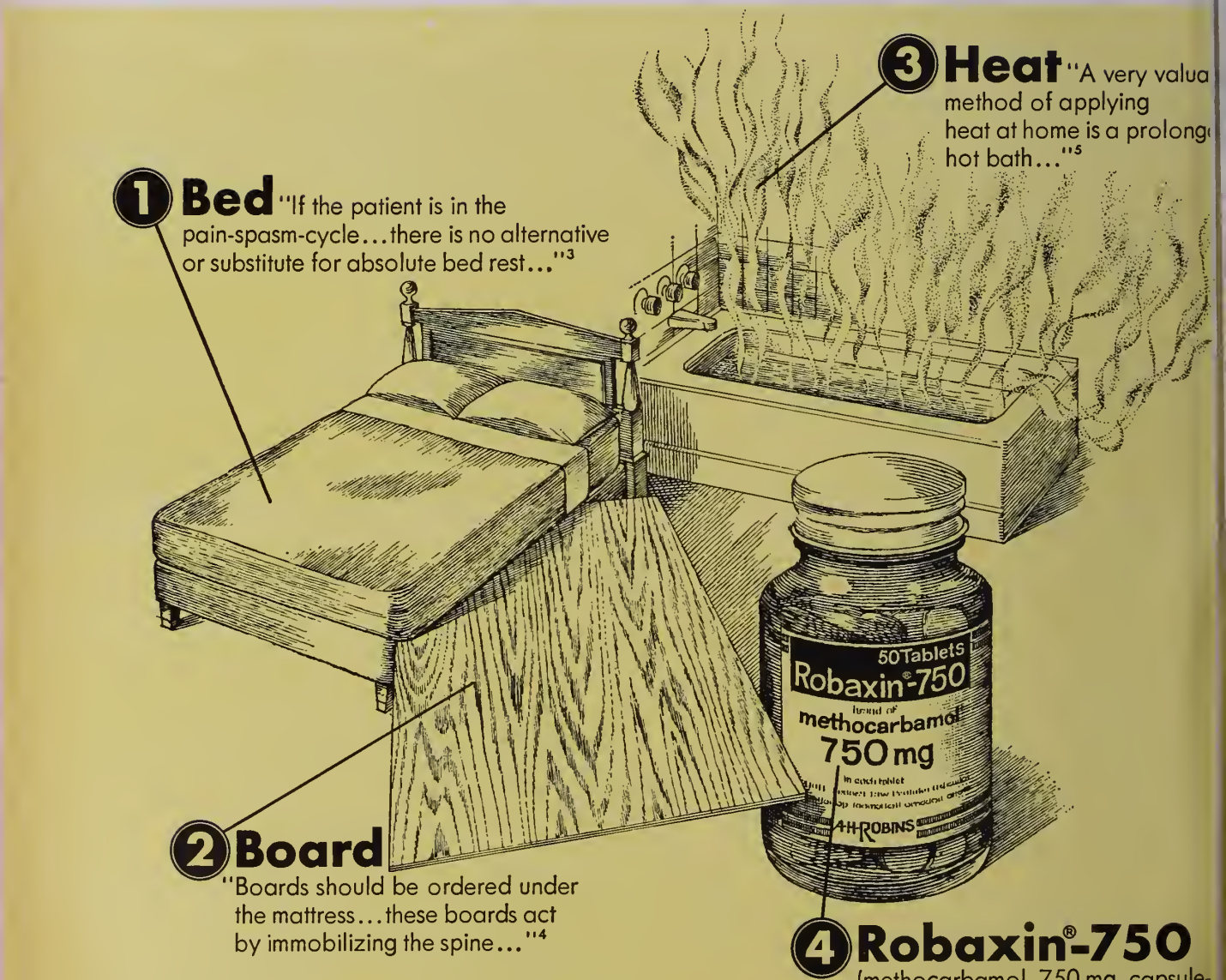
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ORGANIZATION SECTION



New KMA President George F. Brockman, M.D., Greenville (right) repeats the oath of office administered by Rex E. Hayes, M.D., Glasgow, chairman of the Board of Trustees, at the final session of the House of Delegates September 27.

Dr. Asman Named President-Elect By KMA At Annual Meeting

The Kentucky Medical Association chose Henry B. Asman, M.D., Louisville, president-elect at the second session of the House of Delegates, September 27, during the 1967 Annual Meeting in Louisville.



Doctor Asman

Doctor Asman has been serving as secretary of the Association since 1963 and was vice president for the Central District in 1961. He succeeds George F. Brockman, M.D., Greenville, who was installed as president of KMA at the same session of the House. Doctor Brockman succeeds Robert E. Pennington, M.D., London.

A native of Louisville and an alumni of Notre Dame, Doctor Asman graduated from the University of Louisville School of Medicine in 1936. After completing his internship at Louisville General Hospital and his residency training in general surgery at St. Joseph's Infirmary, he entered the practice of coloproctology in 1939 with his father, Bernard Asman, M.D.

Doctor Asman is known for his active participation in medical affairs which includes membership in the Southern Medical Association, Kentucky Surgical Society, Louisville Surgical Society, Catholic Physicians Guild of which he is a past president, and the Board of Directors of the Kentucky Division, American Cancer Society.

A past president of the St. Joseph Infirmary staff where is also Chief of Proctology and a member of the staffs of a number of other Louisville hospitals, Doctor Asman has been a clinical professor of surgery at the University of Louisville School of Medicine from 1939 to 1959.

Doctor Asman is a fellow of the American College of Surgeons and the Southeastern Surgical Congress, an associate fellow of the American Proctologic Society and a past president of the Ohio Valley Proctologic Society.

Vice-presidents of KMA chosen at the September 27 session of the House are Glenn W. Bryant, M.D., Louisville, Central; J. Sankey Williams, M.D., Nicholasville, Eastern; and Luther M. Wilson, Jr., M.D., Bowling Green, Western.

Elected to fill the unexpired term of Doctor Asman as secretary of the Association was S. Randolph Scheen, M.D., Louisville. AMA delegates elected for the term of January 1, 1967 to December 31, 1969 were incumbents John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard. Elected as AMA alternate delegates for the same term were incumbent David B. Stevens, M.D., Lexington, and Daryl P. Harvey, M.D., Glasgow.

Board Elects Dr. Cawood Chairman; Dr. Sehlinger Vice-Chairman

Walter L. Cawood, M.D., Ashland, beginning his second term as trustee for the Thirteenth District, was elected Chairman of the KMA Board of Trustees at the September 28 meeting during the Annual Meeting in Louisville.

George A. Sehlinger, M.D., Louisville, trustee for the Fifth District, was elected Vice Chairman of the Board. Doctor Cawood succeeds Rex E. Hayes, M.D., Glasgow, trustee for the Sixth District, and Doctor Sehlinger succeeds Joseph R. Miller, M.D., Benton, trustee for the First District.

Doctor Cawood graduated from the University of Louisville School of Medicine in 1946 and interned in Nashville before serving from 1947 to 1949 with the Army Medical Corps. Doctor Cawood practiced in Harlan until 1955 and then took his residency training at Johns Hopkins Hospital. He then entered



Doctor Cawood



Doctor Sehlinger

the practice of radiology at Ashland where he has been active in the Boyd County Medical Society and in KMA.

Doctor Sehlinger, a urologist, has practiced in Louisville since 1948. He graduated from the University of Louisville School of Medicine in 1940 and completed his internship and residency training at Louisville General Hospital. He is a diplomate of the American Board of Urology and a Fellow of the American College of Surgeons.

In addition to Doctor Cawood, Donald Chatham, M.D., Shelbyville, trustee for the Seventh District, was elected by the KMA House of Delegates to a second three-year term. Trustees elected to their first three-year terms are William W. Hall, M.D., Owensboro, Second; J. Campbell Cantrill, M.D., Georgetown, Ninth; and Andrew Moore, M.D., Lexington, Tenth.

KMA Woman's Auxiliary Names Mrs. Holmes President-Elect

Mrs. Arthur S. Holmes, Corbin, was chosen president-elect of the Woman's Auxiliary to the Kentucky Medical Association during the Auxiliary's annual meeting in Louisville, September 26-28.

Mrs. Holmes succeeds Mrs. Charles C. Kissinger, Henderson, who was installed as president of the Auxiliary during the meeting. Mrs. Raymond E. Jones, Louisville, the 1966-67 president, presided at this year's session.

Officers re-elected at the meeting include Mrs. F. H. Hodges, Pikeville, first vice-president; Mrs. James A. Harris, Paducah, second vice-president, Mrs. Joseph B. Parker, Jr., Lexington, fourth vice-president; and Mrs. E. C. Hornaday, Owensboro, recording secretary.

New officers elected at the meeting are Mrs. O. J. Stein, Somerset, third vice-president; Mrs. W. B. Blue, Henderson, corresponding secretary; Mrs. Bernard Schoo, Louisville, treasurer; and Mrs. R. Haynes Barr, parliamentarian.

Gubernatorial Candidates Address Annual KEMPAC Seminar

Democrat Henry Ward and Republican Louie Nunn, nominees for governor, presented their political views on topics of interest to the medical profession at the Fifth Annual KEMPAC Seminar September 26 at the Kentucky Hotel.

Some of the topics discussed by the candidates included medical licensure, usual and customary fees, for which both announced their support, taxes, socialized medicine, federal health programs and health facilities in the state.

Malcolm C. Todd, M.D., a California physician representing the AMPAC Board, was also featured on the program. Doctor Todd stressed the need for physicians to participate more actively in politics.

More than 225 physicians and guests attended the Seminar, which was presided over by John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board.



Nicholas P. Dallis, M.D., Scottsdale, Arizona, guest speaker at the President's Luncheon, describes the characters in his comic strip, "Rex Morgan, M.D." in his talk "Life Among the Comic Strip Heroes and Heroines."



Illustrating the characters in "Rex Morgan, M.D." as they are described by Doctor Dallis is one of the comic strip's artists Marvin Bradley, who sketched Doctor Morgan, Melissa and Nancy Willobee.

Creation of a Comic Strip Explained by Dr. Dallis

In a most amusing and informative speech at the President's Luncheon September 27, Nicholas P. Dallis, M.D., Scottsdale, Arizona, author of the nationally famous comic strip, "Rex Morgan, M.D.", gave his audience of nearly 300 physicians and guests a few tips on creating comic strip characters.

Aided by one of his illustrators, Marvin Bradley, who sketched Doctor Morgan, Melissa and Nancy Willobee during his talk, Doctor Dallis explained that his characters were designed to portray the ideal physician, nurse and patient for the public.

Doctor Dallis told his audience how he writes in advance of the appearance of his material with the cooperation of his two artists and gave them a sneak preview of his newest character, Nancy Willobee, who had not yet appeared in the strip at the time of the luncheon.

Also the author of "Apartment 3-G" and "Judge Parker," Doctor Dallis retired from the practice of psychiatry in Toledo in 1959 to devote full time to his writing. He is a 1938 graduate of Temple University School of Medicine and a fellow of the American College of Psychiatrists.



The three winners of KMA's top awards given at the President's Luncheon pose with Richard Grise, M.D., Bowling Green, chairman of the Awards Committee. Pictured from left to right are Doctor Grise; Clyde C. Sparks, M.D., winner of the Distinguished Service Award; Charles E. Tucker, Louisville, recipient of the R. Haynes Barr Award; and William Harrison Jones, M.D., Gray, Outstanding General Practitioner.

Drs. Sparks and Jones, Mr. Tucker Receive KMA's Highest Awards

The Kentucky Medical Association presented its three top awards to Clyde C. Sparks, M.D., Ashland; William Harrison Jones, M.D., Gray; and Charles E. Tucker, Louisville, at the President's Luncheon September 27.

Doctor Sparks, a long-time participant in the activities of the Association, received the Distinguished Service Award. Doctor Jones, who has practiced in Gray for 57 years, was honored with the Outstanding General Practitioner Award.

Mr. Tucker, executive director of the Kentucky Division of the American Cancer Society, was the recipient of the R. Haynes Barr Award given for outstanding service by a layman.

Doctor Sparks has served the medical profession in Kentucky as president of KMA in 1954-55, as chairman of the KMA Board of Trustees, as Speaker of the KMA House of Delegates, and as a member of the Legislative Committee and the Judicial Council. He has long been active in local civic and medical affairs.

A native of Lawrence County, Doctor Sparks received his M.D. degree from the University of Louisville Medical School in 1932 and his surgical training at Louisville General Hospital from 1932 to 1934. He is a fellow of the American College of Surgeons and the Kentucky Surgical Society.

Doctor Jones, the only physician in his area, sees 25 to 30 patients a day and has delivered more than 3,500 babies. A native of Knox County, he attended the University of Tennessee Medical School and graduated from the University of Louisville Medical School in 1909.

For 33 years Doctor Jones has been a physician for the Louisville and Nashville Railroad. He is a past president of the Corbin Medical Society and a staff member of Southeastern Kentucky Baptist Hospital, Corbin, and the Knox County General Hospital, Barbourville.

Recognized throughout the state for his many years of service to the field of medicine, Mr. Tucker has brought nationwide recognition to the Kentucky Division of the American Cancer Society as one of the most progressive divisions in the country. One of his many innovations is the Cancer Mobile.

A native Kentuckian, Mr. Tucker served with the Coast Guard in World War II and with Project HOPE in Africa in 1965. He is a former member of the Board of Directors of the Rehabilitation Center and is on the faculty of Nazareth College in Louisville.

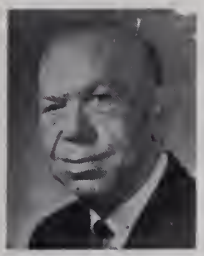
House Chooses Nominating Comm.

A nominating committee composed of the five physicians who will nominate the 1968-69 KMA top officers was chosen by the Association's House of Delegates at its final session September 27.

The members of the committee are Ralph M. Denham, M.D., Louisville; Meredith J. Evans, M.D., Middlesboro; David A. Hull, M.D., Lexington; W. Faxon Payne, M.D., Hopkinsville; and David B. Stevens, M.D., Lexington. The committee will choose its chairman at its first meeting in Covington during the 1968 Interim Meeting April 17 and 18.

Dr. Meredith, Former KMA Officer Dies At Harrodsburg

Thomas O. Meredith, M.D., Harrodsburg, vice-president (Eastern) of the Kentucky Medical Association in 1958-59 and a past president of Blue Shield, died October 8 at the age of 66.



Doctor Meredith

Doctor Meredith, a 1933 graduate of the University of Louisville Medical School, had practiced in Harrodsburg for 30 years. He was a member of the original board of directors of Blue Shield.

In 1961, Doctor Meredith was named Citizen Doctor of the Year by the Kentucky Academy of General Practice. One of his many civic activities included service on the Harrodsburg Board of Education of which he also had been chairman.



George F. Brockman, M.D., Greenville (left) performs his first official act as KMA president in presenting to Robert E. Pennington, M.D., London, outgoing president, a plaque for his outstanding service to the Association.

KMA Gives 1967 Faculty Awards To Drs. Scott and Eiseman

The 1967 KMA Faculty Scientific Achievement awards were presented to Ralph M. Scott, M.D., Louisville, and Ben Eiseman, M.D., formerly of Lexington, at the President's Luncheon September 27, by Richard F. Grise, M.D., Bowling Green, chairman of the KMA Awards Committee.

Since the first presentation of these awards in 1962, the recipients have been selected by the KMA Council on Medical Education and Hospitals for an outstanding contribution to research or other areas of medicine.

Doctor Scott, the award winner from the University of Louisville School of Medicine, was cited for his research, understanding and treatment of Hodgkins Disease. As director of the school's Radiation Treatment and Research Center, Doctor Scott has devoted his time and effort to cancer education and research at both the local and national levels.

Doctor Eiseman, chairman of the department of surgery at the University of Kentucky for six years before returning to Denver this summer, was recognized for his contributions to Kentucky medicine and medical education. While at the University, he established strong teaching and research programs and helped recruit an outstanding faculty. He was twice chosen the outstanding clinical teacher of the year.

Tenth Annual Norton Seminar Scheduled December 14

"Indications for and Results of Various Therapeutic Procedures" will be the theme of the Tenth Annual Norton Seminar, according to Lonnie W. Howerton, Jr., M.D., Louisville, program chairman. Co-sponsored by Norton Memorial Infirmary and the Kentucky Academy of General Practice, the Seminar will begin at 10 a.m. Thursday, December 14, at Norton Memorial Infirmary, Louisville.



Doctor Dustan

Guest speaker at the Seminar will be Harriet Pearson Dustan, M.D., Cleveland, Ohio, a member of the Research Division staff of the Cleveland Clinic Foundation. Doctor Dustan will discuss "Evaluation and Treatment of the Hypertensive Patient." Doctor Dustan, a fellow of the American College of Physicians, is active on councils and committees of the American Heart Association, the Ohio Heart Association and the Heart Association of Northeastern Ohio.

A number of physicians on the Norton Infirmary staff will participate in the program which all physicians are cordially invited to attend, Doctor Howerton said. Some of the topics to be discussed include cardiac arrest, disc surgery, dialysis, cataract surgery, middle ear surgery and arterial surgery of the extremities.



Robert E. Pennington, M.D., London, immediate past president of KMA (center), congratulates President-Elect Henry B. Asman, M.D., Louisville, as new President George F. Brockman, M.D., Greenville, looks on, following the second meeting of the House.



KMA President-Elect Henry B. Asman, M.D., Louisville, receives a standing ovation as he is escorted to the podium by Past Presidents George P. Archer, M.D., Prestonsburg (partially obscured by Doctor Asman), and Delmas M. Clardy, M.D., Hopkinsville, during the final session of the House of Delegates.



At the Second Session of the House of Delegates September 27, W. Vinson Pierce, M.D., Covington, presents the report of Reference Committee No. 6 on the Constitution and Bylaws to the delegates for their consideration.



George F. Brockman, M.D., Greenville, new KMA president (right) and Henry B. Asman, M.D., president-elect, exchange congratulations at the close of the final session of the House of Delegates. They are pictured with S. Randolph Scheen, M.D., Louisville (left), who was elected secretary to fill Doctor Asman's unexpired term, and Keith P. Smith, M.D., Corbin, treasurer.

KMA House of Delegates Considers 17 Resolutions, 56 Reports Of Boards, Committees and Increases Dues at 1967 Meeting

A record number of 17 resolutions, along with many important issues presented by established committees, kept the members of the 1967 KMA House of Delegates unusually busy between September 25 and 27, during the KMA Annual Meeting in Louisville.

Four of the resolutions dealt with the subject of therapeutic abortions; others related to Medicaid, support of KEMPAC, physicians on hospital boards and numerous other matters.

Reports and resolutions submitted to and acted on at the 1967 meeting of the KMA House of Delegates will appear in the December, 1967, issue of The Journal. It will only be possible to touch on some of the highlights of the meeting in this article.

In a surprise action, the House of Delegates suspended its own rules and voted a $5 increase in KMA's annual dues at the final session on Wednesday evening, September 27. The recommended increase, bringing the annual dues to $80, was made by Reference Committee No. 3 after considering the Report of the Council on Legislative Activities for State Affairs. Funds derived from the increase are earmarked for legislative activities.

The four resolutions on therapeutic abortion were offered by Knox, Meade, Mercer and Whitley Counties. In recommending the rejection of these resolutions, the Reference Committee urged the House of Delegates to adopt the same position that was taken by the American Medical Association in June, 1967. It further recommended, "That KMA not assume responsibility of sponsoring legislation to modernize Kentucky's abortion laws."

The AMA position is opposed to induced abortion except when there is documented evidence that continuation of the pregnancy may threaten the health and life of the mother; that the infant may be born with incapacitated physical deformity; that continuation of pregnancy resulting from illegal statutory or forcible rape or incest may constitute a threat to the mental and physical health of the patient; and that two other physicians of recognized professional competence have examined the patient.

The recommendations of the Special Commission to Study the Reorganization of KMA with respect to redistricting the trustee districts, as passed on to the House of Delegates by the Board of Trustees, were actively debated in the Reference Committee. The Commission's proposal that the state be divided on the same basis as congressional districts was rejected by the Reference Committee and upheld by the House of Delegates.

Among the actions taken in the field of Governmental Medical Programs, the House of Delegates passed in amended form resolutions by the Fayette County Medical Society and the Board of Trustees calling on the Kentucky Departments of Health and Economic Security to implement a plan for the payment of physicians on usual, customary and reasonable basis for all services rendered in and out of hospitals within 90 days. Should this request not be made, the Association would advise the entire membership that it no longer urge Kentucky physicians to cooperate in any way with the state administration of these programs. The House of Delegates also recommended that the government use a fiscal agent from the private sector of business in the implementation of the Title XIX program.

The House of Delegates did accept the recommendation of the Special Commission to Study the Reorganization of KMA that was proposed through the Board of Trustees relating to the abandonment of the council and committee structure that the Association has used for the past seven years. The report said that the system simply was not working: that it stifled action and discouraged activity and effectiveness.

In other actions, the House of Delegates accepted a resolution from Jefferson County urging that a physician be placed on all hospital governing boards; rejected a Muhlenberg County resolution calling for mandatory membership in AMA by all KMA members; and accepted Fayette County's resolution urging professionalism in laboratory operations declaring blood transfusions, transplants and related matters as a service; and accepted a Jefferson County resolution commending the efforts of KEMPAC and AMPAC and calling for continued support.

COMPARATIVE REGISTRATION FIGURES

KMA Annual Meetings

	Louisville 1958	Louisville 1959	Louisville 1960	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964	Louisville 1965	Louisville 1966	Louisville 1967
KMA Members	971	997	1021	996	1014	865	924	1172	1016	957
Guest Physicians	166	165	203	194	208	141	157	138	195	152
Interns-Residents	108	128	105	102	102	69	108	132	121	94
Medical Students	269	280	289	237	176	59	128	193	209	222
Registered Nurses	22	34	25	31	59	31	34	27	33	24
Exhibitors	211	200	239	204	232	212	297	297	312	272
Guests	164	86	99	132	123	132	125	172	126	115
Technicians—										
Office Assistants	45	63	33	57	71	22	61	55	46	31
TOTAL ATTENDANCE	1956	1953	2014	1953	1985	1531	1844	2186	2058	1867



George F. Brockman, M.D. Greenville, KMA president, (left) conducts his rounds of the Muhlenberg Community Hospital accompanied by Donn L. Smith, M.D., dean of the University of Louisville School of Medicine (center), and Richard E. Meriwether, hospital administrator. Dean Smith visited Muhlenberg County for a week in October at the invitation of Doctor Brockman.

Dr. Brockman Initiates Study Of Rural Area Practice

At the invitation of George F. Brockman, M.D., Greenville, KMA president, Donn L. Smith, M.D., dean of the University of Louisville School of Medicine, spent the week of October 9-15 in Muhlenberg County observing the type of medical practice carried out in a rural area.

Doctor Brockman, who stated that usually the "country" doctors visit the big cities for new ideas and information, thought it would be helpful to "city" doctors to visit the country for an insight into the problems of medical care in the rural areas.

Dean Smith spent a full week practicing with the 10 physicians in the county in their offices, homes and the Muhlenberg Community Hospital, hoping to discover how well his school is preparing its medical students for this type of practice.

According to Dean Smith, the Muhlenberg County visit was most helpful in preparing him to answer the numerous questions from the students on what will be expected of them if they decide to practice in a rural area. The county physicians enjoyed Dean Smith's visit also and were happy to have his suggestions and assistance.

Doctor Brockman has also invited William R. Willard, M.D., vice president of the University of Kentucky Medical Center, and Russell E. Teague, M.D., Commissioner of Health, to make visits to Muhlenberg County similar to that of Dean Smith. Both doctors are interested in the plan and hope their schedules will allow them to participate in a visit to the "country" in the near future.

KMA Announces 5 New Members

Five physicians became new members of the Kentucky Medical Association recently, according to the records of the membership department as of October 20.

The new members are Robert F. Gloor, M.D., Somerset; Becky John, M.D., Hazard; John M. Karibo, M.D., and N. Alex Saliba, M.D., Louisville; and Kenneth Wier, M.D., Lynch.

Blue Cross, Blue Shield Receive "Employer of the Year" Award

Blue Cross and Blue Shield Plans have been presented with the annual award naming them "Employer of the Year" by Dorcas of Kentucky, Inc. for highest achievement in employing the handicapped.

Dorcas is an organization whose purpose is to educate the public about the handicapped who are 18 years of age and over, to promote employment of this group, and to provide recreational and leadership-inspiring activities for them.

The award was received by Miss Carolyn Taul for Blue Cross and Blue Shield Plans at the Sixth Annual Dorcas Convention held at the Phoenix Hotel, Lexington, in October.



Two Kentucky physicians, Gradie R. Rowntree, M.D., (left) and Robert C. Long, M.D., both of Louisville, attended the 21st World Medical Assembly in Madrid, Spain, September 10-15. Doctor Long, a member of the AMA Board of Trustees, represented the AMA at the meeting, which had a large delegation from the United States. The meeting is held in a different country each year.

Dr. Willard Returns From Vietnam

William R. Willard, M.D., vice president of the University of Kentucky Medical Center, returned in September from a government-sponsored inspection tour of the medical facilities in South Vietnam. Doctor Willard was one of six physicians chosen to participate in the mission. The team was led by F. J. L. Blasingame, M.D., executive vice-president of the AMA.

The group prepared a report to be presented to President Johnson and were also scheduled to appear before the Senate subcommittee on refugees and escapees headed by Senator Edward Kennedy (D-Mass.) to describe their findings.

WMA Asks Journal Program Aid

The World Medical Association urges physicians to participate in a "Doctor-to-Doctor" Program of sending current medical journals to their colleagues in countries abroad where they are unable to obtain them by subscriptions. Any physician interested in this program may obtain further information from Doctor-to-Doctor Program, The World Medical Association, Inc., 10 Columbus Circle, New York, N.Y. 10019.

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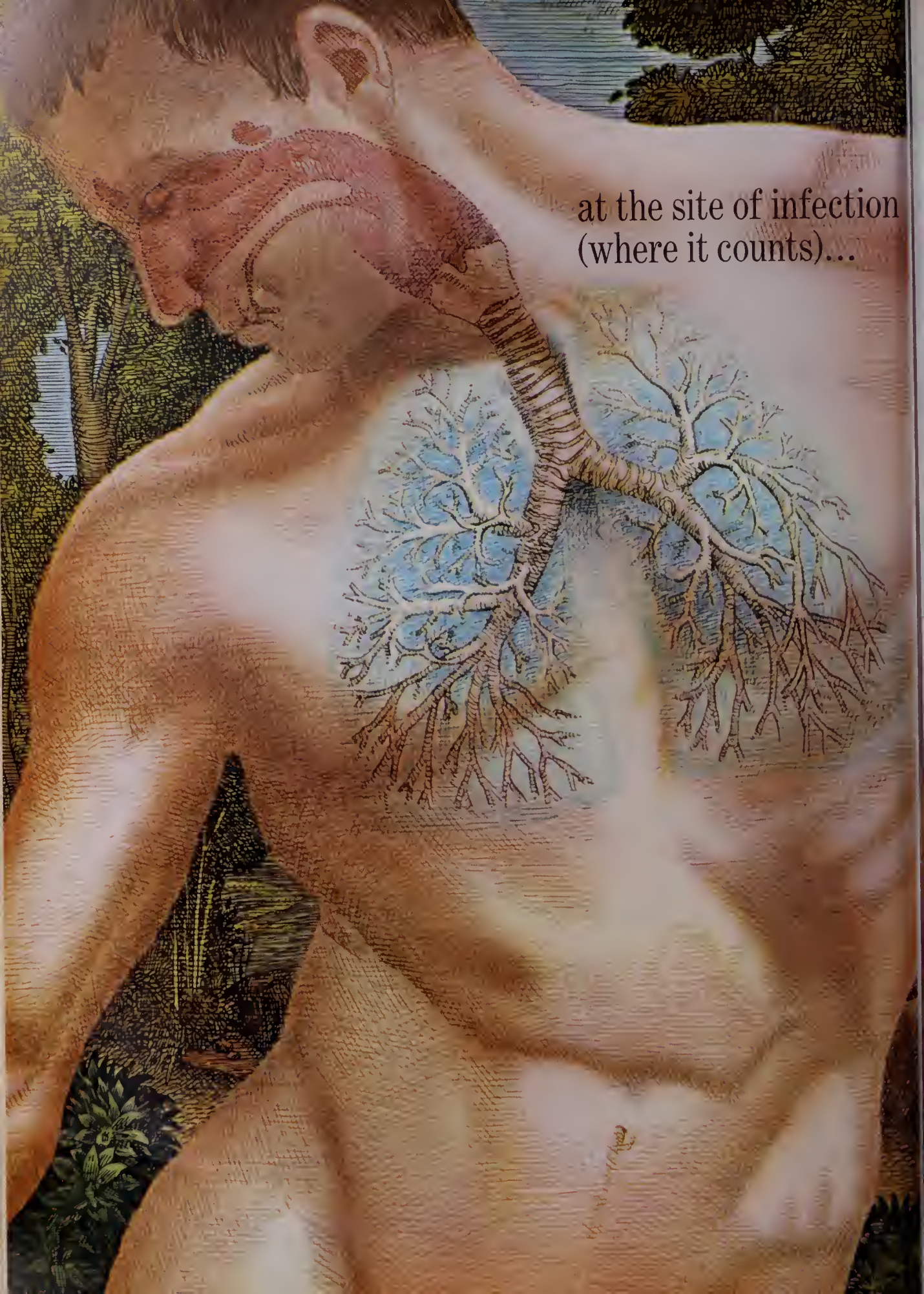
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A


at the site of infection
(where it counts)...

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Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

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Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

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Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

*Base equivalent. [080967]

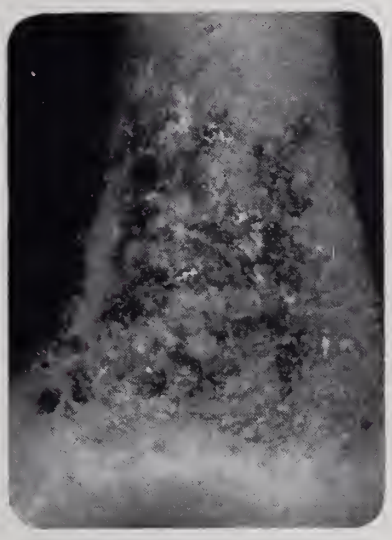
References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

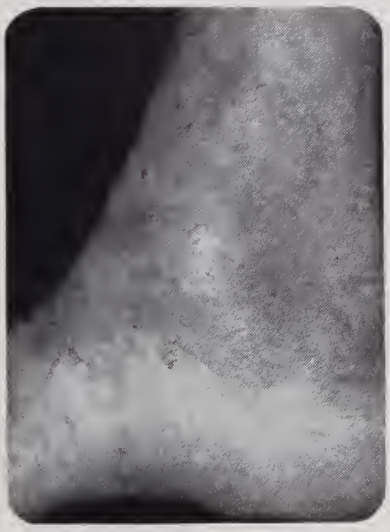
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In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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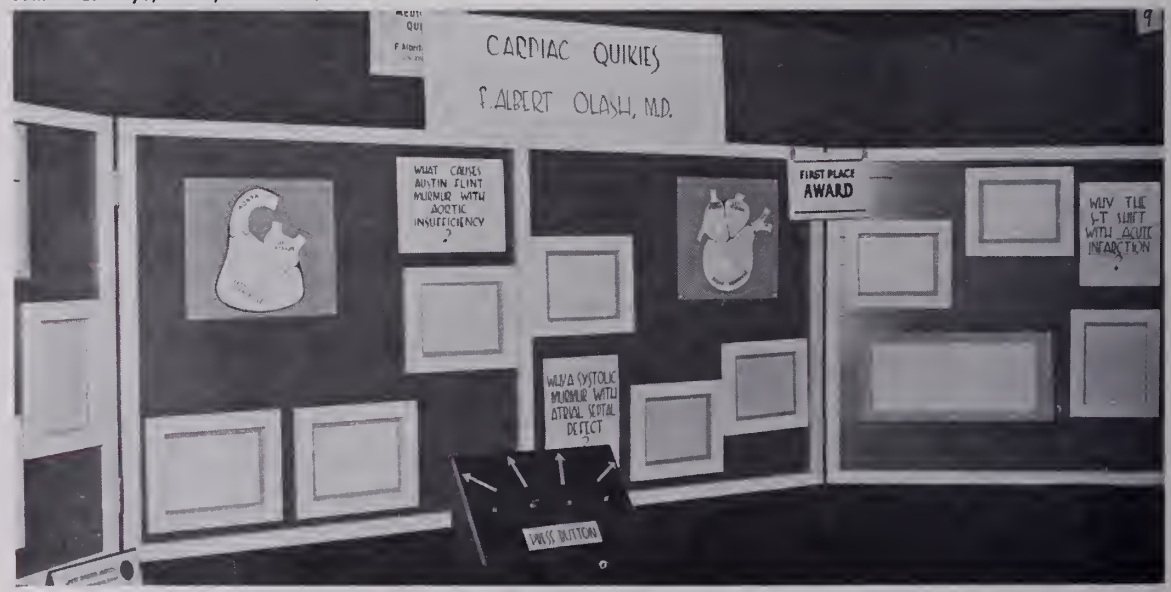
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Members of KEMPAC express their appreciation to the guest speakers at the close of the Fifth Annual KEMPAC Seminar September 25. Pictured from left to right are John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board; Henry Ward, Louisville, Democratic nominee for governor; Malcolm C. Todd, M.D., Long Beach Calif., a member of the AMPAC Board; Louie Nunn, Glasgow, Republican gubernatorial candidate; Hoyt D. Gardner, M.D., Louisville, secretary-treasurer of the AMPAC Board; and Robert E. Pennington, M.D., London, KMA president.



The highlight of the Scientific Program of the 1967 Annual Meeting was a Transatlantic CPC on "Gastrointestinal Hemorrhage" September 27, produced and sponsored by Smith Kline and French Laboratories. Pictures of the British panel members participating in the discussion appear above the members of the American panel which was moderated by James C. Drye, M.D., Louisville.



Selected as the best scientific exhibit at the KMA Annual Meeting, "Cardiac Quikies," pictured above, was presented by F. Albert Olash, M.D., Louisville. A plaque and a $200 check were awarded for the winning exhibit.

Fifth KMA Orientation Program Reports Record Attendance

N. Lewis Bosworth, M.D., chairman of the KMA Committee on Communications and Health Education, reported a record attendance of 68 physicians at the Fifth Orientation Program for new members, September 25.

The KMA Orientation Program, approved in a bylaw amendment by the House of Delegates in September, 1964, is held at least twice annually, in conjunction with the Interim Meeting and the Annual Meeting.

Listed below are the names of the physicians who attended the September, 1967, program. If you attended this session and your name was inadvertently omitted, it is requested that you advise the KMA Headquarters Office.

J. W. Bard, M.D., Lexington
John A. Barrow, M.D., Henderson
P. Bruce Barton, M.D., Corbin
Franklin K. Belhasen, M.D., Paintsville
Benjamin S. Bell, M.D., Lexington
T. F. Burke, M.D., Hopkinsville
Woody G. Burrow, M.D., Paducah
Arthur Butterfield, M.D., Lexington
Peter C. Campbell, M.D., Louisville
Frank S. Cascio, M.D., Lexington
Robert B. Cloar, M.D., Lexington
Frederick G. Cox, M.D., Pikeville
Philip Crawford, M.D., Lexington
John R. Curtis, M.D., Lexington
Russell H. Davis, M.D., Pikeville
S. Singh Dhanjal, M.D., Louisville
Louis D. Dublier, M.D., Lexington
A. J. Dzenitis, M.D., Louisville
S. G. Edelstein, M.D., Lexington
John D. Fielding, M.D., Warsaw
Samuel W. Gehring, M.D., Flemingsburg
Bernard D. Greenwell, M.D., Vine Grove
M. A. Greenwell, M.D., Elizabethtown
William Handley, M.D., Elizabethtown
Amalia A. Hickman, M.D., Cold Spring
Warren T. Hill, M.D., Russellville
Louis J. Kahle, M.D., Louisville
Leslie E. Karr, M.D., Corbin
Marie M. Keeling, M.D., Louisville
William H. Klompus, M.D., Madisonville
Paul G. Kyker, M.D., Lexington
Antonio U. Lira, M.D., Covington
Harold V. Markesbery, M.D., Florence
Aaron S. Mason, M.D., Lexington
John W. McClellan, M.D., Henderson
Francine Middleman, M.D., Lexington
Harold K. Mines, M.D., Cadiz
William T. Moore, M.D., Glasgow
K. M. Neudorfer, M.D., Ashland
Robert A. Noel, M.D., Louisville
Charles R. Oberst, M.D., Louisville
Luigi C. Pacini, M.D., Louisville
John Parks, M.D., Lexington
Donald L. Pedersen, M.D., Lexington
W. L. Pesci, M.D., Danville
Giovanni Raccuglia, M.D., Louisville
Frank E. Reeder, M.D., Paducah
Evaristo Riestra, M.D., Ashland
David R. Ringel, M.D., Louisville
Robert M. Runge, M.D., Campbell
Edward I. Rustin, M.D., Pikeville
J. E. Sadtler, M.D., Louisville
Marthe M. Saint Pierre, M.D., Louisville
James C. Seabury, Jr., M.D., Paducah
Harvey Sloane, M.D., Louisville
B. E. Spencer, M.D., Louisville
Don R. Stephens, M. D., Cynthiana
John M. Stoeckinger, M.D., Lexington
Charles E. Vanetti, M.D., Lexington
S. T. Vanover, M.D., Shepherdsville
Raymond D. Wells, M.D., Inez
Craig Wetzelberger, M.D., Louisville
Stanley D. Wheeler, M.D., Crestwood
Robert H. Wilber, M.D., Lebanon
Jonathan D. Wirtschafter, M.D., Lexington
Mary L. Wiss, M.D., Hyden
C. M. Young, III, M.D., Louisville
Walter H. Zukof, M.D., Louisville

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Membership in KMA Surpasses 1966 Record This Year

The total number of active physicians in the state who are active members of KMA has reached 2247 this year as compared to 2235 in 1966, according to the records of the membership department.

This year 58 counties have 100% membership in KMA and 40 counties have 100% membership in both KMA and AMA. These figures are slightly lower than last year's numbers which were 66 counties and 46 counties respectively.

While membership in KMA has increased, membership in AMA has decreased from 2003 KMA members in 1966 to 1917 in 1967.

The following chart contains figures obtained from the membership department as of October 15. They do not include associate and emeritus members.

Number of Active Physicians in Kentucky Counties Who Are Members of KMA and AMA

October 15, 1967

COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA	COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA	COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA
Adair	7	6	6	Graves	15	14	14	Menifee (*)	2	2	1
Allen	6	5	5	Grayson	5	4	4	Mercer	13	12	11
Anderson	4	3	2	Green	7	6	5	Metcalfe (*) (**)	1	1	1
Ballard (*)	4	4	3	Greenup (*) (**)	8	8	8	Monroe (*) (**)	7	7	7
Barren	24	23	22	Hancock	2	0	0	Montgomery	9	8	6
Bath	4	1	1	Hardin	24	23	13	Morgan (*)	3	3	2
Bell	25	20	18	Harlan	38	37	37	Muhlenberg (*)	12	12	11
Boone (*) (**)	14	14	14	Harrison (*)	7	7	4	Nelson	9	8	8
Bourbon	15	12	5	Hart (*) (**)	6	6	6	Nicholas (*)	3	3	1
Boyd	52	51	50	Henderson	29	27	27	Ohio	6	5	4
Boyle	23	15	11	Henry (*) (**)	3	3	3	Oldham	9	8	7
Bracken (*) (**)	2	2	2	Hickman (*) (**)	2	2	2	Owen	3	2	2
Breathitt (*) (**)	3	3	3	Hopkins	43	39	37	Owsley (*) (**)	2	2	2
Breckinridge (*) (**)	5	5	5	Jackson (*) (**)	1	1	1	Pendleton (*)	3	3	1
Bullitt (*) (**)	4	4	4	Jefferson	830	755	602	Perry	16	15	13
Butler (*) (**)	2	2	2	Jessamine	5	4	2	Pike	56	28	28
Caldwell	6	5	5	Johnson (*) (**)	12	12	12	Powell	2	1	1
Calloway	15	14	14	Kenton — See Campbell				Pulaski (*)	26	26	24
Campbell-Kenton	153	142	118	Knott (*) (**)	2	2	2	Robertson	1	0	0
Carlisle (*) (**)	2	2	2	Knox	7	6	3	Rockcastle	2	1	0
Carroll (*)	5	5	4	Larue	4	3	1	Rowan	10	9	9
Carter	5	2	1	Laurel (*)	9	9	8	Russell (*) (**)	3	3	3
Casey (*) (**)	5	5	5	Lawrence	8	6	6	Scott (*)	9	9	2
Christian	39	33	33	Lee (*) (**)	2	2	2	Shelby (*) (**)	7	7	7
Clark	14	13	12	Leslie	4	2	2	Simpson (*)	6	6	3
Clay (*) (**)	5	5	5	Letcher	16	10	9	Spencer (*) (**)	2	2	2
Clinton (*) (**)	2	2	2	Lewis (*)	2	2	1	Taylor (*) (**)	6	6	6
Crittenden (*) (**)	2	2	2	Lincoln (*) (**)	4	4	4	Todd (*) (**)	3	3	3
Cumberland (*) (**)	2	2	2	Livingston	4	3	2	Trigg (*)	6	6	5
Daviess	69	67	62	Logan	11	10	10	Trimble (*) (**)	2	2	2
Edmonson (*) (**)	2	2	2	Lyon	4	3	1	Union	5	4	4
Elliott	2	1	1	McCracken	63	51	49	Warren	43	41	39
Estill (*) (**)	5	5	5	McCreary	3	2	2	Washington (*) (**)	4	4	4
Fayette	381	298	257	McLean	4	3	0	Wayne (*)	6	6	5
Fleming (*)	4	4	1	Madison	27	24	19	Webster	5	4	4
Floyd	21	10	9	Magoffin (*) (**)	2	2	2	Whitley (*)	19	19	17
Franklin	36	30	27	Marion	10	8	8	Wolfe (*) (**)	1	1	1
Fulton	10	9	9	Marshall (*) (**)	9	9	9	Woodford	9	6	2
Gallatin (*) (**)	1	1	1	Martin (*) (**)	2	2	2				
Garrard (*) (**)	3	3	3	Mason	14	12	10	Total —	2569	2247	1917
Grant (*) (**)	4	4	4	Meade (*)	3	3	1				

* 100% KMA ** 100% AMA

Note: Report includes teaching staffs at medical schools, physicians in public health, mental institutions, TB hospitals, VA hospitals, etc.

Boyd Co. Health Officer Retires

A. M. Lyon, M.D., health officer of the Ashland-Boyd County Health Department, retired September 28 due to illness. He had held that position since 1960. Doctor Lyon was also health officer for Greenup County.

Doctor Lyon has served in many health capacities throughout his medical career. He was in private practice at Sandy Hook for 14 years during which time he also served as health officer for Elliott County. He was superintendent of the Kentucky Training Home, Frankfort for 10 years, superintendent of Western State Hospital, Hopkinsville, and of Central State Hospital, Lakeland.

Two manuscript competitions have been announced by the Industrial Medical Association. The first offers a $300 award to the medical student, intern or resident for the best manuscript pertaining to occupational health. The second is for residents in occupational medicine only. Contest rules may be obtained from the Industrial Medical Association, 55 E. Washington St., Chicago, Ill., 60602.

Was Your Delegate Present?

ROLL CALL—

1967 House of Delegates

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Richard F. Greathouse	Present	Present
Vice-Speaker	Carl Cooper, Jr.	Present	Present
President	Robert E. Pennington	Present	Present
President-Elect	George F. Brockman	Present	Present
Vice-President	Roy H. Moore, Jr.	.....	.....
Vice-President	J. Campbell Cantrill	.....	Present
Vice-President	James A. Harris	Deceased	
Secretary	Henry B. Asman	Present	Present
Treasurer	Keith P. Smith	Present	Present
Delegate to AMA	J. Thomas Giannini	Present	Present
Delegate to AMA	Charles C. Rutledge	Present	Present
Delegate to AMA	John C. Quertermous	Present	Present
Alternate Delegate to the AMA	Charles G. Bryant	Present	Present
Alternate Delegate to the AMA	William W. Hall	.....	.....
Alternate Delegate to the AMA	David B. Stevens	Present	Present

TRUSTEES

District			
First	Joseph R. Miller	Present	Present
Second	W. Gerald Edds	Present	Present
Third	Gabe A. Payne, Jr.	Present	Present
Fourth	Henry B. Spalding	Present	.....
Fifth	George A. Sehlinger	Present	Present
Sixth	Rex E. Hayes	Present	Present
Seventh	Donald Chatham	Present	.....
Eighth	Leroy C. Hess	Present	Present
Ninth	Mitchel B. Denham	Present	.....
Tenth	Douglas E. Scott	Present	Present
Eleventh	Douglas H. Jenkins	Present	Present
Twelfth	Robert F. Long	.....	Present
Thirteenth	Walter L. Cawood	Present	Present
Fourteenth	Ballard W. Cassady	Present	Present
Fifteenth	E. C. Seeley	Present	Present

PAST PRESIDENTS

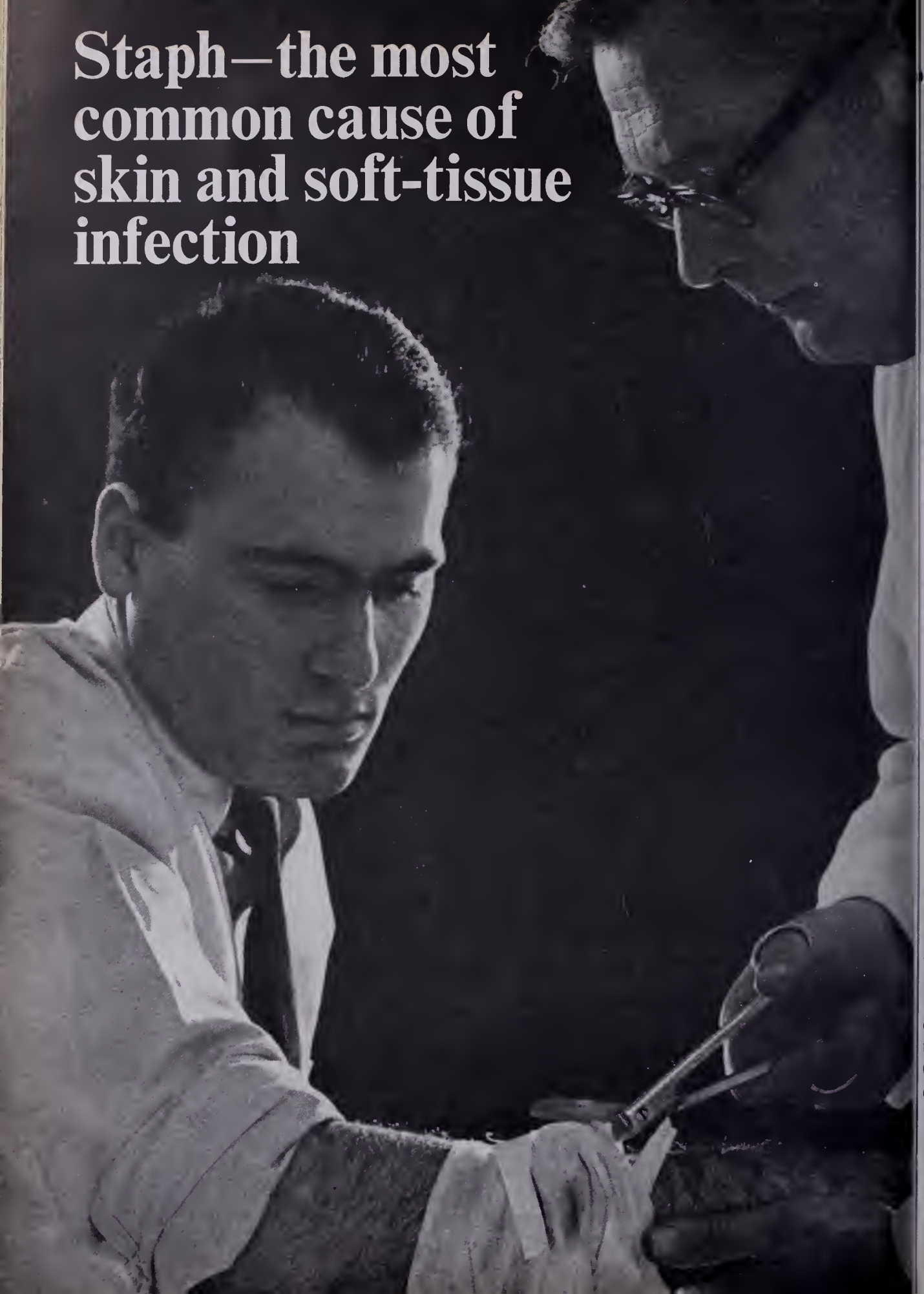
Past President	Everett H. Baker	Present	Present
Past President	Delmas Clardy	Present	Present
Past President	George Archer	Present	Present
Past President	David M. Cox	Present	Present
Past President	Gaithel L. Simpson	.....	.....

DELEGATES

County		First Session	Second Session
First District			
BALLARD	Glenn Baird	.....	.....
CALLOWAY	C. C. Lowry	Present	Present
CARLISLE	John T. O'Neill	.....	.....
FULTON	R. W. Bushart	.....	.....
GRAVES	Larry L. Hall	.....	.....
HICKMAN	C. J. Mills	.....	.....
LIVINGSTON		.....	.....
McCRACKEN	James Embry	Present	Present
	Walter Johnson	Present	Present
	Ed Davis (Alt.)	.....	Present
MARSHALL	Keith Ellis	Present	Present
Second District			
DAVIESS	J. H. Kurre	Present	.....
	Reginald J. Phillips	Present	Present
	Joseph C. Stiles	Present	.....
HANCOCK		.....	.....
HENDERSON	Kenneth Eblen	Present	Present
	Charles Kissinger	Present	Present
McLEAN	Everett S. Coleman	.....	Present
OHIO	Robert Norsworthy	Present	.....
UNION	Wallas Bell	Present	.....
WEBSTER		.....	.....
Third District			
CALDWELL	B. G. Jackson	.....	.....
CHRISTIAN	W. Faxon Payne	Present	.....
	Norma T. Shepherd	Present	Present
CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	Loman C. Trover	Present	.....
	Frederick Scott	Present	Present
LYON	Robert H. Hyde	.....	.....
MUHLENBERG	Robert Robbins	Present	Present
TODD	Ralph D. Lynn	Present	Present
TRIGG	Ronald W. Howard	Present	.....
	Thornton Bryan (Alt.)	.....	Present
Fourth District			
BRECKINRIDGE	James G. Sills	Present	Present
BULLITT	W. B. Hamilton	Present	Present
GRAYSON	Ralph G. Thomas	Present	Present
GREEN	George C. Cheatham	Present	Present
HARDIN	Fred C. Rainey	Present	Present
HART		.....	.....
LARUE	Marion A. Douglas, Jr.	Present	Present
MARION	Robert H. Wilber	Present	.....
MEADE		.....	.....
NELSON	Kenneth L. Stinnette	Present	Present
TAYLOR	H. F. Chambers	.....	.....
WASHINGTON	Dixie Snider	Present	Present
Fifth District			
JEFFERSON	James Baker	Present	Present
	C. Melvin Bernhard	Present	Present
	Charles J. Bisig	.....	Present
	Thomas E. Campbell	Present	Present
	Eugene H. Conner	Present	Present
	William Durham	Present	Present
	Harold G. Eskind	Present	Present
	Wesley Farnsley	Present	Present
	Jeremiah Flowers (Alt.)	.....	Present
	John Goldsborough	.....	Present
	Cecil Grumbles	Present	Present
	Stuart Harlowe	.....	Present
	John Hemmer	.....	Present
	Walter I. Hume, Jr.	Present	Present
	Herman Mahaffey	.....	Present
	Roy A. Martin	Present	Present
	Robert L. McClendon	Present	Present
	Clyde Moore	Present	Present
	Herman Moore	Present	Present
	F. Albert Olash	.....	Present
	Bernard Popham	Present	Present
	John Robbins	.....	Present
	W. Fielding Rubel	Present	Present
	S. Randolph Scheen	Present	Present
	E. B. Schoenbachler	Present	Present
	Charles C. Smith	Present	Present
	Donn L Smith	Present	.....
	Edwin P. Solomon (Alt.)	.....	Present
	Robert S. Tillett	Present	Present
	William VonderHaar	Present	Present
	Will W. Ward	.....	.....
	Ralph Whitehead (Alt.)	Present	Present
Sixth District			
ADAIR	M. C. Loy	Present	Present
ALLEN	Earl P. Oliver	Present	Present
BARREN	William H. Bryant	Present	Present
BUTLER		.....	.....
CUMBERLAND	Joseph Schickel	Present	.....
EDMONSON		.....	.....
LOGAN	John P. Glenn	Present	Present
METCALFE		.....	.....
MONROE	Kenneth Crabtree	.....	.....
SIMPSON	Airzzie Greene	Present	.....
WARREN	Paul J. Parks	Present	Present
	L. M. Wilson, Jr.	Present	Present
Seventh District			
ANDERSON	Boyd Caudill	Present	Present
CARROLL	Edgar S. Weaver	.....	.....
FRANKLIN	Harold L. Johnson	Present	Present
	Sanford L. Weiler	Present	Present
GALLATIN		.....	.....
GRANT	C. C. Waldrop	Present	Present
HENRY	S. B. May	Present	.....
OLDHAM		.....	.....
SHELBY	Stephen F. Collins	Present	Present
SPENCER		.....	.....
TRIMBLE	Carl Cooper, Jr.	Present	Present
Eighth District			
BOONE	Glenn F. Baird (Alt.)	Present	Present
CAMPBELL	Carl J. Brueggemann	Present	Present
KENTON	Donald K. Dudderar	Present	Present
	Thomas L. Heavern	Present	.....
	Paul Klingenberg	Present	Present
	Robert T. Longshore	Present	.....
	W. Vinson Pierce	Present	Present

**The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 25 and 27.*

Staph—the most common cause of skin and soft-tissue infection



reliably controlled with specific therapy



A suitable dosage form for every staph situation

Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co., Syracuse, N.Y.

Whenever you suspect staph PROSTAPHLIN®

SODIUM OXACILLIN

AMA '67 HOUSTON

AMA 21ST CLINICAL CONVENTION • ASTROHALL • HOUSTON, TEXAS • NOVEMBER 26-29, 1967

Plan to attend this year's AMA Clinical Convention in Houston, Texas. Eighteen scientific sessions, four postgraduate courses, breakfast roundtable discussions, color television, and scientific and industrial exhibits will bring you up to date on the latest medical advances. Attend lectures by, and discussions with, our nation's outstanding medical authorities.

Between sessions, enjoy the excellent restaurants, fine shops, visitors' attractions, and mild winter temperatures Houston offers. Mail the enclosed registration and room reservation coupons now, and look forward to an exceptional convention with a holiday plus.

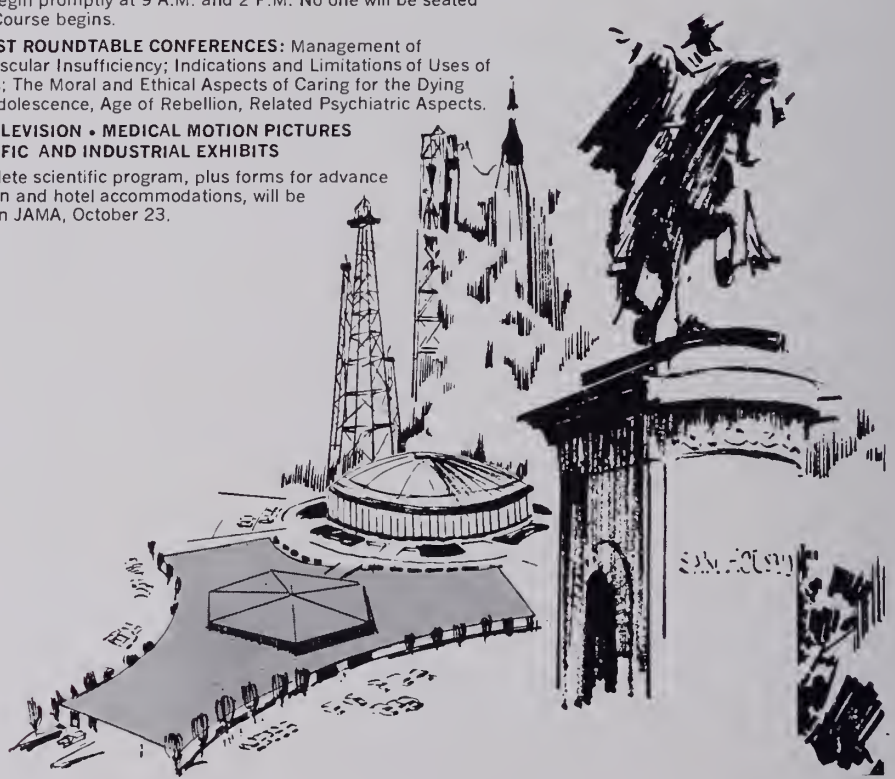
SCIENTIFIC SESSIONS: Cardiovascular Disease; Cardiovascular Surgery; New Cares; Ophthalmology; Geriatrics; Arthritis; Gastroenterology; Cancer; Antibiotics; Endocrinology; General Surgery; Dermatology; Aerospace Medicine; Obstetrics and Gynecology; Psychiatry; Pediatrics; Genitourinary Diseases; and Otolaryngology.

POSTGRADUATE COURSES: Fluid and Electrolyte Balance; Oncology; Cardiovascular Disease; and Obstetrics and Gynecology. Register for these Courses on arrival in Houston at the PG Course Registration booth adjacent to the General Registration area. There is no charge for the Courses, but registration is limited to 200 per Course. The Courses begin promptly at 9 A.M. and 2 P.M. No one will be seated after the Course begins.

BREAKFAST ROUNDTABLE CONFERENCES: Management of Cerebrovascular Insufficiency; Indications and Limitations of Uses of Antibiotics; The Moral and Ethical Aspects of Caring for the Dying Patient; Adolescence, Age of Rebellion, Related Psychiatric Aspects.

COLOR TELEVISION • MEDICAL MOTION PICTURES • SCIENTIFIC AND INDUSTRIAL EXHIBITS

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, October 23.



		First Session	Second Session
	Ninth District		
BATH		.....	.....
BOURBON	James L. Ferrell	Present	Present
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	Samuel W. Gehring	.....	Present
HARRISON	Don R. Stephens	.....	Present
MASON		.....	.....
NICHOLAS	W. R. Kingsolver	.....	.....
PENDLETON	William M. Townsend	.....	.....
ROBERTSON		.....	.....
SCOTT	D. Vertress Hollingsworth	Present	Present
	Tenth District		
FAYETTE	John F. Berry, Jr.	Present	.....
	Leslie W. Blakey	Present	Present
	N. L. Bosworth	.....	Present
	Thomson R. Bryant, Jr.	Present	Present
	Richard D. Floyd	Present	Present
	Carl H. Fortune	Present	Present
	David A. Hull	Present	Present
	Irvin F. Kanner	Present	Present
	Richard McElvein (Alt.)	Present	Present
	Andrew Moore	Present	Present
	John E. Myers	Present	Present
	Joseph Saunders	.....	Present
	David B. Stevens	.....	Present
JESSAMINE	J. Sankey Williams	.....	.....
WOODFORD	William J. Graul	Present	Present
	Eleventh District		
CLARK	Harold Moberly	.....	.....
ESTILL	Charles E. Terry	.....	.....
JACKSON		.....	.....
LEE		.....	.....
MADISON	R. Eugene Bowling	Present	Present
	William D. Epling	Present	Present
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	M. B. Gabbard	.....	.....
POWELL	Charles G. Noss	.....	.....
WOLFE	Paul F. Maddox	.....	.....
	Twelfth District		
BOYLE	John M. Baird	Present	.....
CASEY	G. J. Sweeney	Present	Present
CLINTON	E. A. Barnes	.....	.....
GARRARD	Paul E. Lett	Present	.....
LINCOLN	H. I. Frisbie	.....	.....
McCREARY		.....	.....
MERCER	James M. Keightley	Present	.....
PULASKI	S. B. Kelley	.....	Present
	William M. Wyatt	Present	Present
ROCKCASTLE		.....	.....
RUSSELL	James E. Monin	.....	.....
WAYNE	Robert B. Breeding	.....	Present
	Thirteenth District		
BOYD	John Harrison	Present	Present
	Max Wheeler	Present	Present
CARTER		.....	.....
ELLIOTT	Brown L. Adkins	.....	.....
GREENUP	John O. Jones	.....	.....
LAWRENCE	George P. Carter	.....	Present
LEWIS		.....	.....
MORGAN	George Bellamy	.....	.....
	Alec Spencer (Alt.)	Present	.....
ROWAN	F. Calvin Bigler	Present	Present
	Fourteenth District		
BREATHITT		.....	.....
FLOYD	James A. Holbrook	Present	Present
JOHNSON	A. B. Carter	.....	Present
KNOTT	Gene Watts	.....	Present
LETCHER	Jim B. Tolliver	.....	Present
MAGOFFIN	Lloyd M. Hall	.....	.....
MARTIN	Raymond D. Wells	.....	.....
PERRY	Donald L. Martin	Present	Present
PIKE	Harvey A. Page	Present	Present
	Fifteenth District		
BELL	Meredith J. Evans	Present	.....
	Francis A. Forde (Alt.)	.....	Present
CLAY	W. E. Becknell	Present	Present
HARLAN	Henry C. Evans	Present	Present
	Doane Fischer	Present	Present
KNOX	H. L. Bushey	Present	Present
LAUREL	Paul R. Smith	Present	Present
LESLIE	Mary Pauline Fox	Present	Present
WHITLEY	Harold B. Barton	Present	.....



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital an
One-Half Sodium Secobarbita
supplied in ¾, 1½, and 3-grain Pulvule



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

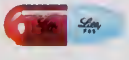
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
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Lilly

Synirin®

ACETYLSALICYLIC ACID (ASPIRIN)..... 5 GR.
*PENTOBARBITAL (ACID)..... 1/8 GR.
*Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

SYNIRIN is another pharmaceutical achievement

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Dr. Lykins Elected Vice-Speaker Of ASA House of Delegates

Robert W. Lykins, M.D., Louisville, was elected Vice Speaker of the House of Delegates of the American Society of Anesthesiologists October 3.



Doctor Lykins

Doctor Lykins has served the Kentucky Medical Association as its vice-president for the Central District in 1962-63.

His election as Vice Speaker took place at the final session of the House during the Society's annual meeting September 29-October 3 in Las Vegas.

1967 Annual Meeting Guests Express Pleasure to KMA

"Your hospitality is overwhelming!! We had a wonderful time and we are certainly grateful to you for all your courtesies. Thanks so much."

Newton DuPuy, M.D.
President
Illinois State Medical Society
Chicago, Illinois

"I thoroughly enjoyed my visit with your group and am deeply grateful for the many kindnesses shown to me. Please accept my thanks for a most pleasant occasion."

Lester Adelson, M.D.
Pathologist and Chief Deputy Coroner
County of Cuyahoga
Cleveland, Ohio

"It was nice to see you again after all these years. Needless to say, I thoroughly enjoyed the visit to Louisville."

Nicholas P. Dallis, M.D.
Scottsdale, Arizona
Author of "Rex Morgan, M.D."

"It was fun to have visited in Louisville, and I was delighted to have been with you at the KEMPAC Seminar."

Malcolm C. Todd, M.D.
Long Beach, California
AMPAC Board Member

"I appreciated the invitation to address your Scientific Assembly and enjoyed my stay in Louisville. It was nice meeting you and, except for the weather, appreciated your hospitality."

Franklin J. Evans, M.D.
Coral Gables, Florida

"I wish to thank you very much for your warm hospitality, and it was a very exciting two days for me."

Satoru Nakamoto, M.D.
Head, Department of Hemodialysis
Cleveland Clinic Hospital
Cleveland, Ohio

"It was a pleasure for me to participate in your very fine meeting."

Loren J. Humphrey, M.D., Ph.D.
Department of Surgery
University of Kentucky Medical Center
Lexington, Kentucky

"I would like to thank you and your associates for the hospitality showed me when I was a guest of the Kentucky Medical Association and assure you that I enjoyed myself there."

Adolph Rostenberg, Jr., M.D.
Department of Dermatology
University of Illinois
Chicago, Illinois

"I enjoyed my visit to Louisville. Doctors Berry and Shepard were most kind and helpful and the visit with Phyllis Knight was pleasant as well as interesting."

Frederic N. Silverman, M.D.
Director, Division of Roentgenology
Children's Hospital
Cincinnati, Ohio

"Lester Adelson, M.D., commented to me that the communications to him from the Kentucky Medical Association were amazing because of the efficiency with which they were carried out. He was extremely impressed with your office. Of course, it makes members proud to have such organization behind them. Thank you for your courtesies to Doctor Adelson."

Duane N. Tweeddale, M.D.
Department of Pathology
University of Kentucky Medical Center
Lexington, Kentucky

"I enjoyed immensely being with your group, which I found a very interested, active and vital group of physicians."

Nat T. Winston, Jr., M.D.
Commissioner of Mental Health
Nashville, Tennessee

"Please accept my thanks again for allowing me to participate in the recent meeting of the Kentucky Medical Association. I found it most enjoyable and productive, and you are to be congratulated on the high quality of the meeting."

James F. Glenn, M.D.
Chief, Urology
Duke University Medical Center
Durham, North Carolina

(Continued on page 1139)

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or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
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(Continued from page 1137)

"I wish to thank you personally for your courtesy while I was a guest of the Kentucky Medical Association."

Lawrence C. Meredith, M.D.
Past President
Ohio State Medical Association
Elyria, Ohio

"Thank you for your very kind hospitality. I truly enjoyed my stay and particularly the very receptive audience during the banquet session, as well as the scientific meeting. Thank you again for your many kindnesses."

Emanuel M. Skolnik, M.D.
Otolaryngologist
Skokie, Illinois

Doctor Gumbert Elected President Of Two Organizations

George M. Gumbert, Jr., M.D. Lexington, was elected president of the Kentucky Orthopaedic Society and of the Flying Physicians Association at meetings of the two groups in September.



Doctor Gumbert

Other officers elected by the Orthopaedic Society are Joseph Stiles, M.D., Owensboro, vice president, and Kenneth Phillips, M.D., Lexington, secretary-treasurer.

The Flying Physicians Association elected Doctor Gumbert during their 13th annual meeting in Williamsburg, Virginia. The five-day session was held to promote aeromedical safety.

Public Health Page

(Continued from page 1057)

These and other epidemiological relationships were determined which will allow the selection of criteria to identify those women who are least likely to have ever had a Papanicolaou smear. This will assist in making the educational aspect of this program even more productive during the second year.

• Opportunity •

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can yield excellent returns. Invest now in National Growth & Investment Co., Inc., which is negotiating to acquire two important investment properties in Louisville. Shares available at same price paid by original incorporators—local, respected businessmen. For prospectus and complete information, send your name and address to NGI, 420 W. Liberty, Louisville, Ky., or call 893-3434 after 6.

Microsurgical Technique

(Continued from page 1085)

The main advantages of the technique, utilizing the operating microscope are:

1. Finer control in tissue handling and inspection.
2. Point cautery to control bleeding with minimal electrocoagulation.
3. Accurately measured combined vertical-bevel type incision.
4. Accurate point apposition of cornea to sclera.
5. Precise placement of forceps and needles in corneal and scleral borders.
6. Uniformity of management and tying of sutures.

(Generic and Trade Names—Acetylcholine: Miochol)

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Medical College of Virginia
Richmond, Virginia 23219

Include curriculum vitae and recent photograph.

In Memoriam

GUY P. GRIGSBY, M.D.

Louisville

1884-1967

Guy P. Grigsby, M.D., 82, a retired surgeon, died October 6 in Louisville where he had practiced for 50 years. Doctor Grigsby retired from private practice 10 years ago. He was a member of the American College of Surgeons.

Myelomeningocele

(Continued from page 1081)

a variety of problems, many quite serious, it is felt that the best hope of obtaining optimal care lies in the establishment of a special clinic for these children in which each child will be seen by a team of specialists at each clinic visit.

References

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Ky. Physicians in the Armed Forces

James Brashear, M.D., Central City, returned from Vietnam September 11 and will be stationed at Ft. Campbell until his discharge in January. During his tour of duty in Vietnam, Doctor Brashear assisted in the opening of the 12th Evacuation Hospital last December.

Reversed Colon Segment

(Continued from page 1091)

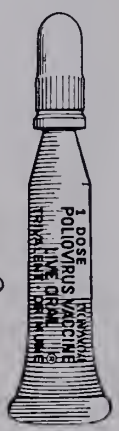
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SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.

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Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



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METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

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Eutonyl affords a different kind of basic therapy for moderate to severe cases

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In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
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See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

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Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions.* Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

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ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

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Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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NOVEMBER

16 Obstetrics and Gynecology Grand Rounds, "Anesthesia," University of Kentucky Medical Center, Lexington

17-18 Kentucky Thoracic Society, Fall Case Conference, Boone Tavern Hotel, Berea

30 Obstetrics and Gynecology Grand Rounds, "Normal Labor," University of Kentucky Medical Center, Lexington

DECEMBER

7 Fourth Trustee District, 5 p.m., Holiday Inn, Elizabethtown

7 Obstetrics and Gynecology Grand Rounds, "Immediate Problems in First 24 Hours Post Partum," University of Kentucky Medical Center, Lexington

13 Industrial Medical Association, Holiday Inn, Brownsboro Road, Louisville

14 Tenth Annual Postgraduate Medical Seminar, 10 a.m., Norton Memorial Infirmary, Louisville

14 Obstetrics and Gynecology Grand Rounds, "Delayed Problems—24 Hours to 6 Weeks Post Partum," University of Kentucky Medical Center, Lexington

21 Obstetrics and Gynecology Grand Rounds, "Management of Patients at 6 Weeks Post Partum," University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

NOVEMBER

13-16 Southern Medical Association, Miami Beach, Fla.

13-17 "Diagnosis and Treatment of Diseases of the Heart and Lungs," American College of Chest Physicians Postgraduate Program, Barbizon-Plaza, New York City.

15-16 Cleveland Clinic Educational Foundation postgraduate course, "Pain: Neurological and Neurosurgical Aspects," Cleveland

15-18 American College of Physicians, Postgraduate Course, "Neurologic Aspects of Internal Medicine," Duke University Medical Center, Durham, North Carolina

26-29 American Medical Association's Clinical Convention, Astro Hall, Houston

DECEMBER

4-6 Southern Surgical Association, The Homestead, Hot Springs, Va.

JANUARY

20-25 American Academy of Orthopaedic Surgeons, Palmer House, Chicago

SEND IN MEETING INFORMATION

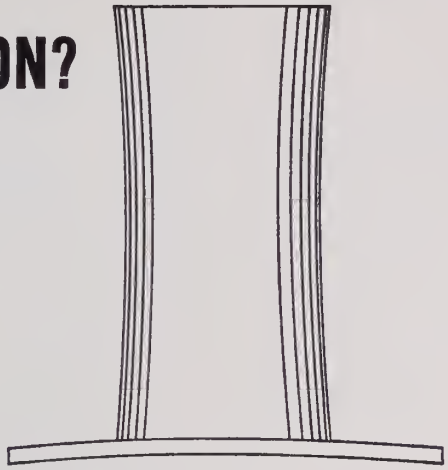
Many medical organizations are setting dates for their winter and spring meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Educational Opportunities" calender in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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KMA 1968 Interim Meeting—April 17-18

Statler-Hilton Motel, Covington

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(diphenylhydantoin)

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JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

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Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Summary of prescribing information

Indications: Urinary tract infections in which gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas*. Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

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· **For children**—Caplets of **250 mg.**, available in bottles of 56 and 1000.

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References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

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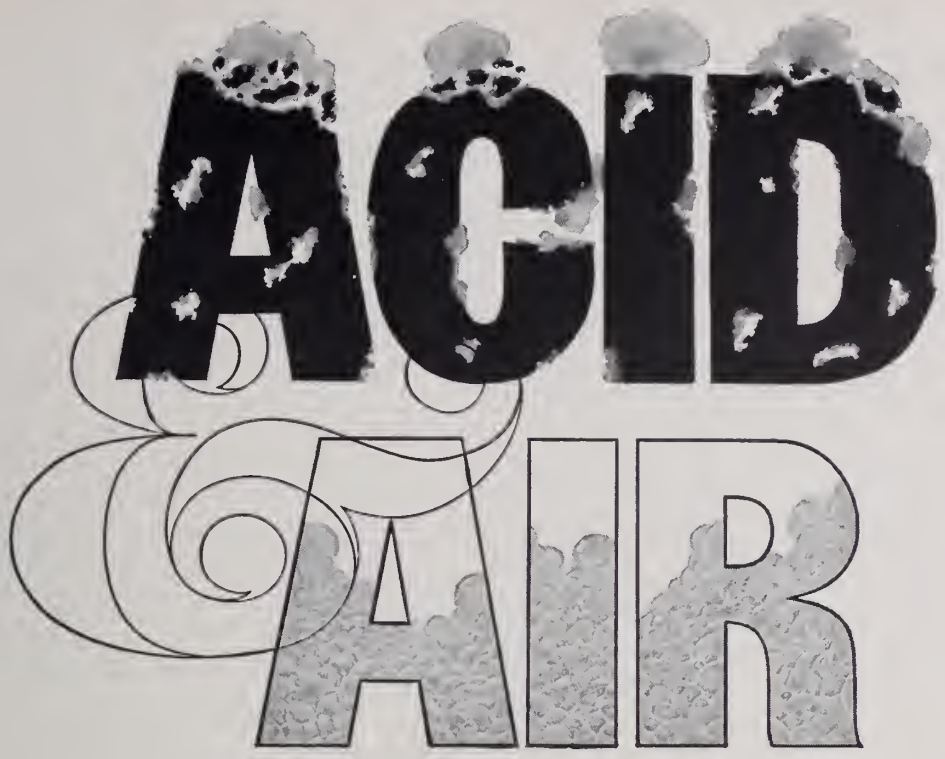
Our overworked colleagues at home, and the sick with unmet needs.

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Our staff.

May we hope the New Year will bring to all of us the strength to do better, and the wisdom to be grateful and modest.

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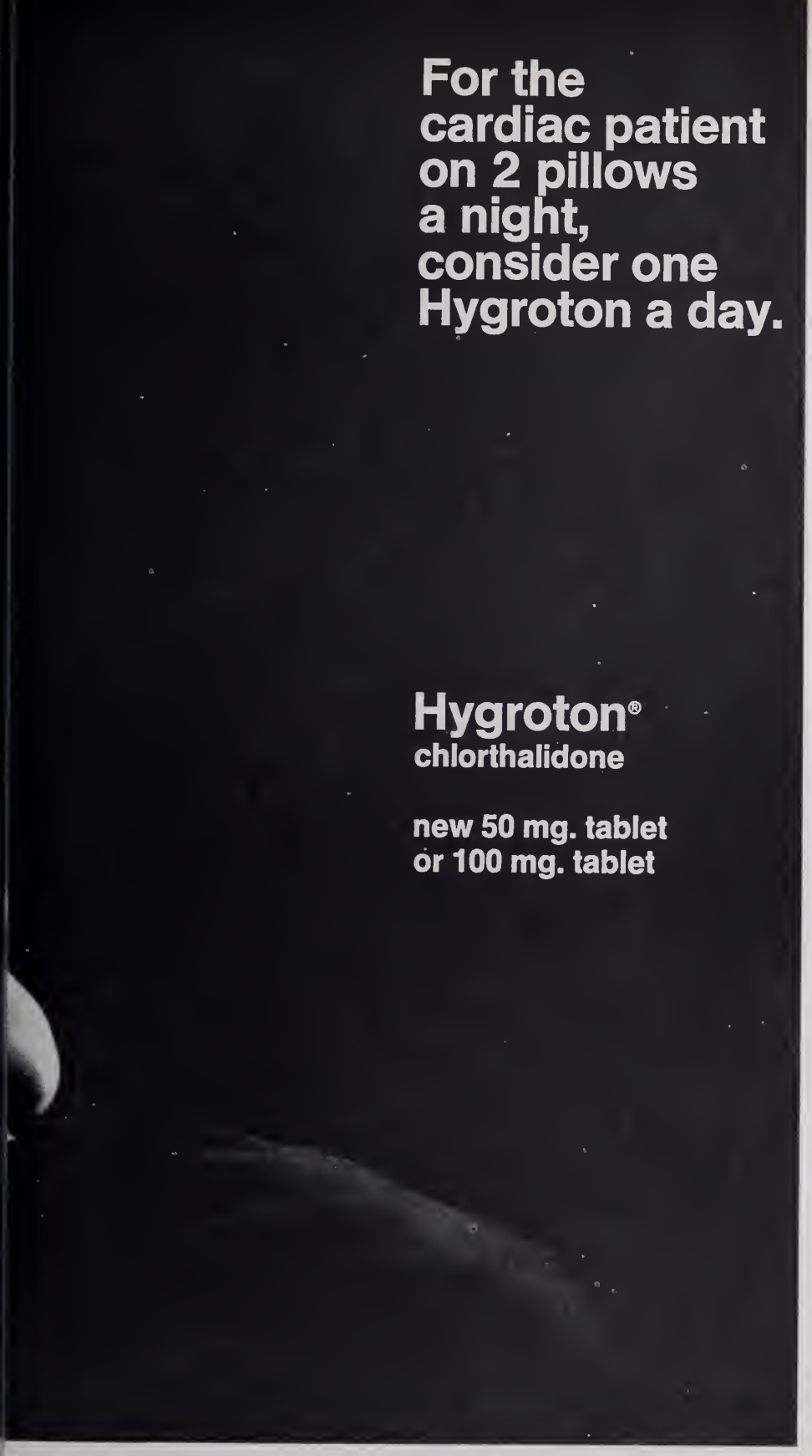
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(B)R46-230-D
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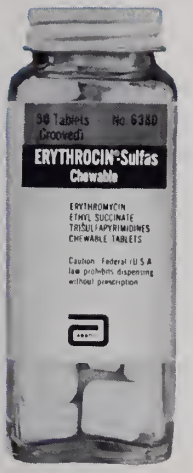
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inical cure rate of 94.5%

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Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

Reports on File, Dept. Clin. Development, tt Laboratories.
y, R.F.L., Use of Erythromycin-Sulfas in Office ice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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The first edition will be distributed in January 1968. This publication is made possible through the cooperation of the Kentucky, Indiana, and Ohio State Medical Associations and is sponsored by Lederle Laboratories.

Your cooperation is requested in sending all information concerning medical meetings, courses, and future educational opportunities for publication in this brochure. Send all information to G. S. Accetta, M.D., 320 Broadway, Cincinnati, Ohio 45202. (Phone: Area 513-721-2345)

IN KENTUCKY

DECEMBER

14 Tenth Annual Postgraduate Medical Seminar, 10 a.m., Norton Memorial Infirmary, Louisville

14 Obstetrics and Gynecology Grand Rounds, "Delayed Problems—24 Hours to 6 Weeks Post Partum," University of Kentucky Medical Center, Lexington

21 Obstetrics and Gynecology Grand Rounds, "Management of Patients at 6 Weeks Post Partum," University of Kentucky Medical Center, Lexington

JANUARY

4 Obstetrics and Gynecology Grand Rounds, "Management of Diabetes in Pregnancy," University of Kentucky Medical Center, Lexington

11 Obstetrics and Gynecology Grand Rounds, Estriol as a Yardstick of Fetal Well-being," University of Kentucky Medical Center, Lexington

17 Methodist Evangelical Hospital Third Annual Postgraduate Day, Hospital Conference Room, Louisville

18 Obstetrics and Gynecology Grand Rounds, "Operative Management of Complicated Pregnancy," University of Kentucky Medical Center, Lexington

25 Obstetrics and Gynecology Grand Rounds, "Resuscitation of Newborn," University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

JANUARY

17 Post Graduate Symposium in Nuclear Medicine, "Introduction to Nuclear Medicine," Washington University School of Medicine, St. Louis, Mo.

17-18 Cleveland Clinic Educational Foundation Postgraduate Course, "The Treatment of Surgical Emergencies," Bunts Auditorium, Cleveland

18-19 Post Graduate Symposium in Nuclear Medicine, "Progress in Nuclear Medicine," Washington University School of Medicine, St. Louis, Mo.

20-25 American Academy of Orthopaedic Surgeons, Palmer House, Chicago

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their winter and spring meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

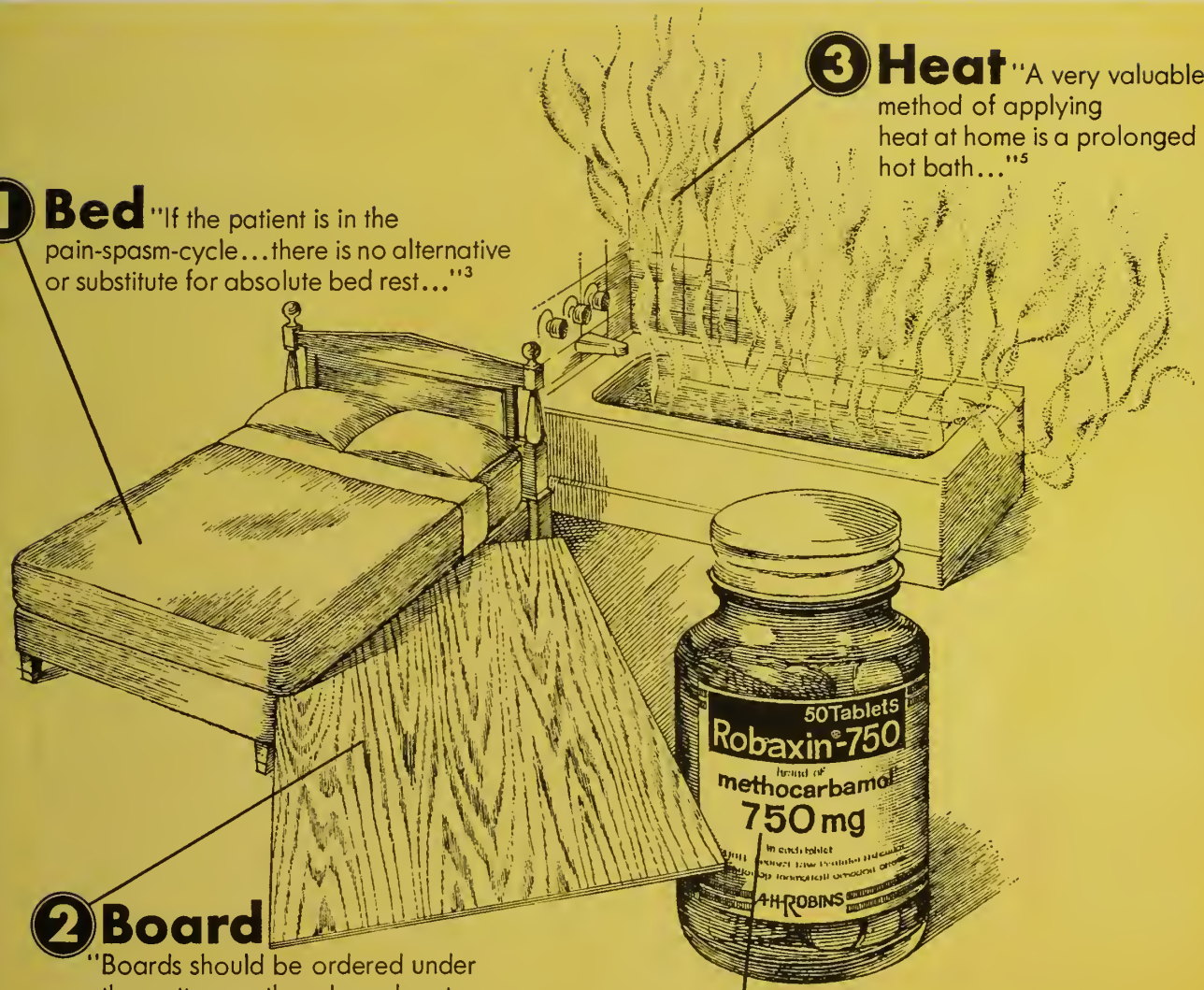
The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Educational Opportunities" calender in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

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References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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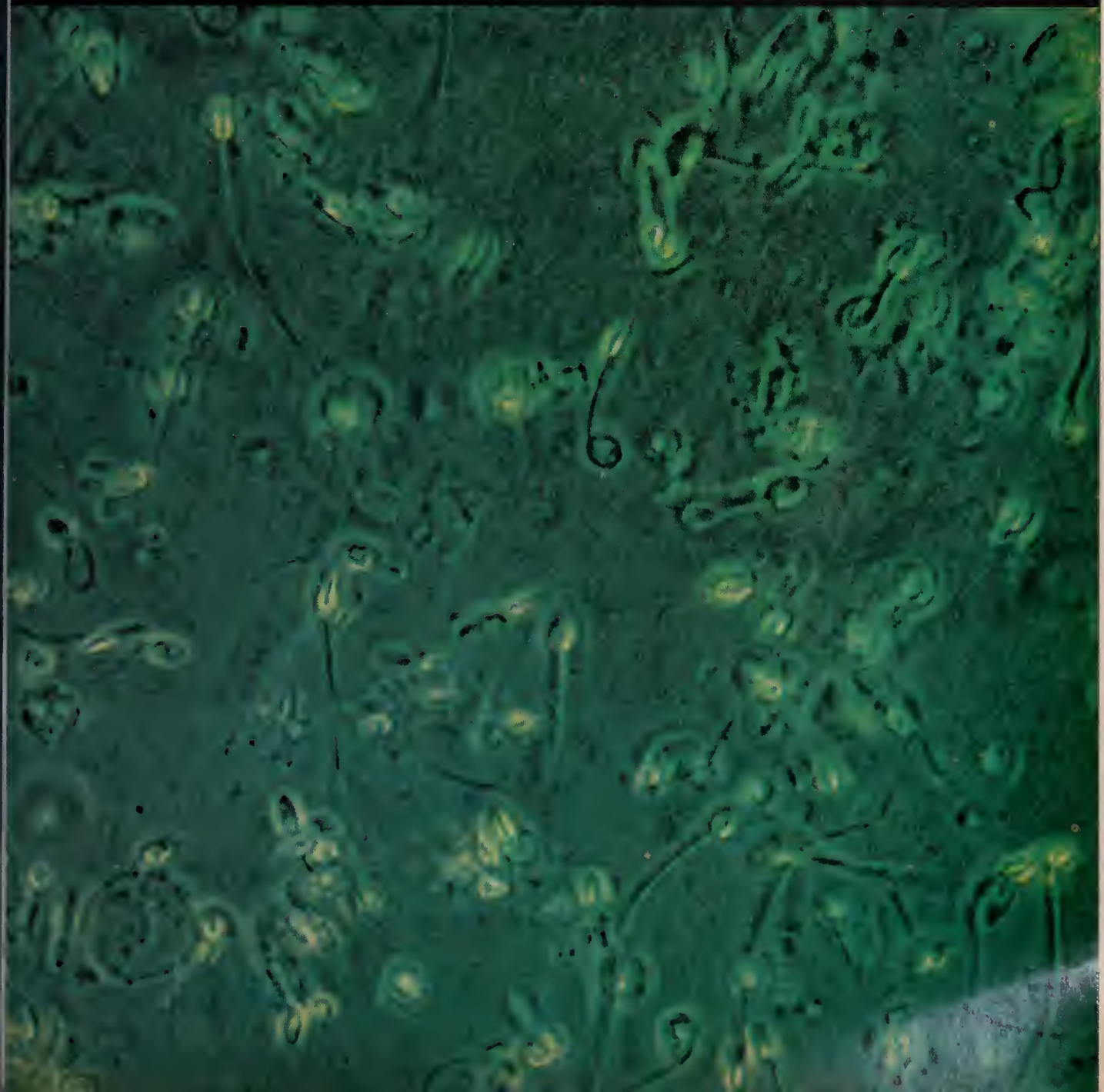
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Turn page for contraindications, precautions and side effects.



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Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incide in patients receiving oral contrace tives: nausea, vomiting, gastroint tinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, eden chloasma or melasma, breast chan (tenderness, enlargement and secretion), change in weight (incre or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when giv immediately postpartum, cholest jaundice, migraine, rash (allergic) rise in blood pressure in susceptib individuals, mental depression. Although the following side effect have been reported in users of ora contraceptives, no cause and effec relationship has been established: anovulation posttreatment, preme struallike syndrome, changes in libido, changes in appetite, cystiti like syndrome, headache, nervous ness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, a itching. The following occurrences have been observed in users of ora contraceptives (a cause and effect relationship has neither been estal lished nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests ma be altered by the use of oral contra ceptives: increased sulfobromoph thalein and other hepatic functi tests, coagulation tests (increase i prothrombin, factors VII, VIII, IX and X), thyroid function (increase PBI and butanol extractable protei bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

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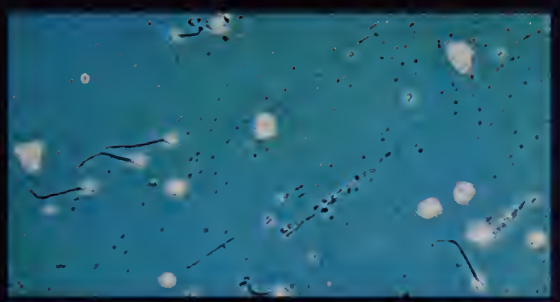
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

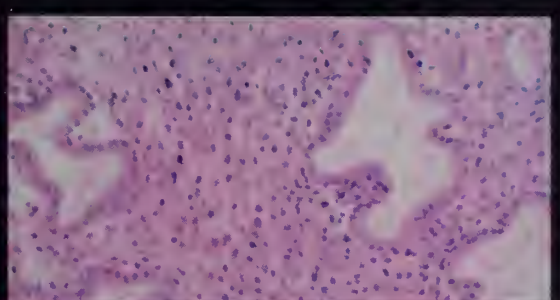
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

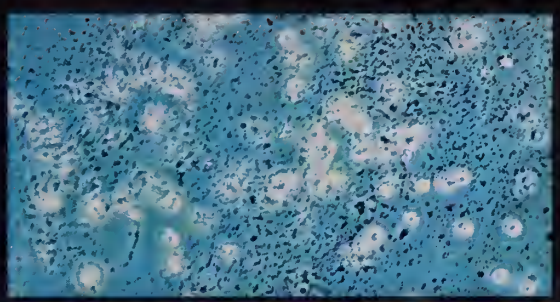


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

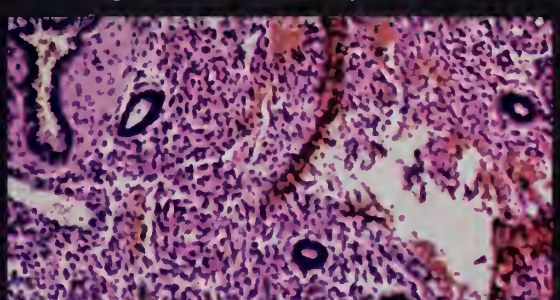
Norinyl-1 Patient



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Synalar®
fluocinolone acetonide





Turn page for contraindications, precautions and side effects.

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Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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INFANT NUTRITION, Samuel J. Fomon, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1967; 299 Pages; Price, $10.50.

The author, a distinguished clinician and nutritionist, Doctor Fomon, has devoted much of his professional life in research efforts to the infant metabolism unit, department of pediatrics, University of Iowa. This volume is in a way a summary of the experience, contributions, and achievements of the author and the unit toward a better understanding of infant nutrition and metabolism. He uses selected references and his own work instead of attempting to give comprehensive attention to the literature in the field. He accomplished a very worthwhile purpose of providing, for the thoughtful physician, nutritionist and dietician, "a working definition of failure to thrive . . . so that one may distinguish between slow rates of growth that may yet be considered normal and those slightly slower rates that are to be considered abnormal." Also a very clear definition of obesity in infancy is presented.

Basic information regarding foods, vitamins, minerals and water is presented in sufficient depth to permit better understanding of the clinical and biochemical adorations of normal and abnormal nutrition and corrective measures. The author avoids or mentions briefly many of the current challenges and controversies in the field. In his excellent chapter "Infant Feeding in Health and Disease" the reviewer would like to have seen some mention of the influence of early feeding, especially of prematures, on the decreasing incidence of hyperbilirubinemia, hypoglucosemia, dehydration, acidosis, tyrosinemia, phenylalinemia, etc. Although the author mentions the importance of lower serum proteins in infants fed soy protein formulae, he does not mention the especial dangers of such formulas in treating patients with cystic fibrosis of the pancreas. He discusses, briefly, dietary therapy for a few inborn errors of metabolism and has excellent tables and references for many others.

In the chapter on the "Future of Infant Nutrition," problems regarding diet and longevity, diet and incidence of disease, nutritional imprinting and nutritional influence on somatic and mental development offer much food for thought. Doctor Fomon has no doubt accomplished many of his goals in this small, well organized and written volume even to the appendices on composition of foods and metabolic balance studies. Physicians, nutritionists, dieticians and students of growth and development will welcome this volume to help them care for problem infants and to gain a better understanding of infant nutrition.

B. F. Andrews, M.D.

PATHOLOGY, Third Edition: by Stanley L. Robbins, M.D.; Published by W. B. Saunders Company, Philadelphia and London, 1967; 1434 Pages; Price, $20.50.

With the "explosion" in knowledge that is going on today it must be a hard task indeed to write a medical textbook or even a new edition of a medical textbook. "Pathology" by Stanley L. Robbins, M.D., is certainly no exception to this.

The third edition was published in June, 1967. Since it tips the scale at something over seven pounds, it is perhaps best left on the student's desk.

Doctor Robbins' book has a strong clinical orientation which is good. Most signs and symptoms of organic disease have alterations in structure or function as their basis. Since the electron microscope is now showing us altered structure where heretofore we had only altered function, it is appropriate that the number of electron micrographic illustrations has been considerably increased.

All but five of the 32 chapters are by Doctor Robbins himself. This gives the book a certain coherency often lacking in texts where each chapter is by a different "specialist."

Two new chapters are included. One is "Genetics and Disease" where entries such as Klinefelter's syndrome, Von Gierke's disease and PKU, previously scattered throughout the book, are now tied up in one package. The chapter is richly illustrated with karyotypes not found in the earlier edition.

The other new chapter, "Diseases of Aging" by Henry Unger, M.D., represents an entirely new addition. Though a mere 10 pages it supplies a needed emphasis and will probably grow in the future.

Robbins' "Pathology" can be recommended as a satisfactory compromise between two opposing forces. One of these aims at conciseness and is seen in the current trend in medical education to emphasize principles and concepts and trim away "unnecessary details." The other force is simply the compelling need for important emerging facts to be disseminated. Actually, Robbins does an admirable job in not losing the principles in the details.

Regarding the omission of details thought by some to be necessary he remarks "the omissions are either a considered judgement of my error"—a statement which should make the critic think twice!

Wallace L. Past, M.D.

easy does it!

tear, moisten, compare–that's all!



The JOURNAL of the
Kentucky Medical Association

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VOLUME 65 December 1967 No. 12

Hemostatic Failure During Surgery†

PHIL J. HARBRECHT, M.D.*
Louisville, Kentucky

Abnormal bleeding may occur during surgery in a patient who previously showed no sign of hematologic abnormality. The more probable etiologic factors and the therapeutic considerations are reviewed.

PATIENTS with obvious hematologic defects may present complicated problems at surgery. However, most of these problems may be anticipated and expert consultation obtained as needed. Rarely will the surgeon be forced into an unwelcome sole responsibility for critical hematologic decisions on these patients.

The surgeon may be more directly involved in hematologic decisions on patients who have no apparent previous disorder but develop an abnormal bleeding fault during surgery. For one reason, the bleeding tendency may have been created or potentiated by adjunctive therapy or other aspect of the surgical scene. For another, the initial responses to the urgent, transient situation may determine the eventual outcome. Barring the rare instances where a trained hematologist is an active member of the surgical team, it behooves the surgeon to understand the circumstances that predispose to abnormal bleeding and the basic therapeutic considerations.

†*From the Department of Surgery, University of Louisville School of Medicine, and Louisville Veterans Administration Hospital*
**Acting Chief, Surgical Service, Veterans Administration Hospital, Louisville*

The pertinent literature is only rarely focused on the needs of the surgeon. It is complex, technical and frequently inconclusive. A recent symposium[1], devoted entirely to bleeding in the surgical patient, is an excellent source of provocative articles but by no means entirely solves the problems. Much, however, has been learned in recent years and we have attempted to summarize some of the advances in two recent reviews[2,3]. The bibliographies attached to those reviews include a few articles of general surgical interest[4,5,6]. A recent small textbook[7] has surgical co-authorship and is recommended as of practical value.

This paper will review the hemostatic mechanism, the types of hemorrhagic disease, and finally the defects in hemostasis that the surgeon will most frequently encounter at the operating table. Much oversimplification will be necessary and the presentation is intended only as an introduction to the subject.

The Hemostatic Mechanism

Hemostasis. Hemostasis involves extravascular and vascular factors. Contraction of blood vessels, slowing of blood flow, pressure in the surrounding tissue, and other local factors are important. Increased permeability of the vascular wall on a congenital, infectious, nutritional, or allergic basis may play at least a contributory role in deficient hemostasis. However, in most bleeding problems at the operating table we deal with defects of the platelets and coagulation factors.

Hemostasis may be divided into three steps. (Fig. 1.) In the first two steps the platelets

I. Vasoconstriction. Platelets adhere to damaged endothelial cells and to exposed collagen fibers. This is followed by reversible platelet aggregation.

II. Viscous metamorphosis. Formation of firm irreversible platelet thrombus.

III. Coagulation of plasma. Conversion of white platelet thrombus to a red fibrin thrombus

FIGURE 1. STEPS IN HEMOSTASIS

play the predominant role. Primary hemostasis does not require the third step. In congenital absence of fibrinogen the third step is impossible and in heparin therapy it is impaired but there is usually no spontaneous hemorrhage. However, if injury to the vessel wall occurs, bleeding is apt to be profuse as the platelet clot retracts. The fibrin clot is the essential factor in secondary hemostasis.

The Hemostatic Balance. The ability of blood to clot can only be considered in reference to its ability to remain fluid inside the vessels. Repulsive electrical charges of endothelium and blood components, dispersion and dilution of coagulation factors by blood flow, natural anticoagulants in the body, and the fibrinolytic system of the body are important factors in keeping blood fluid.

The factors favoring coagulation and those inhibiting it are in a state of dynamic equilibrium. The delicate balance may be shifted toward bleeding either through a deficiency of coagulation factors, through an increase in natural anticoagulants, through an overactivity of the fibrinolytic system, or any combination of these.

Blood Coagulation. Morawitz in 1905 presented the classical theory of blood coagulation. Thromboplastin in the presence of calcium changes prothrombin to thrombin, which in turn converts fibrinogen into fibrin. This is valid today, but important advances have been made. Additional blood clotting factors beyond the four of the classical theory have been found. If we transpose these new factors into a modern concept of coagulation almost all are involved in the formation of thromboplastin. The elements of the classical theory remain unchanged. We also have additional knowledge as to the final steps in production of a tough hemostatically effective fibrin clot.

There is practical value in dividing coagulation into three stages. (Fig. 2.) The formation of plasma thromboplastin is the first stage. It can be evaluated by appropriate tests, and a defect is usually hemophilia. The conversion of plasma thromboplastin into activated thromboplastin and the change of prothrombin to thrombin is stage two, is measured by the prothrombin time, and a defect is usually due to a dicumarol-like drug, malabsorption, or hepatic disease. The conversion of fibrinogen into fibrin is stage three, is measurable by the lab, and a defect usually involves consumption of fibrinogen in clotting or destruction by fibrinolysis.

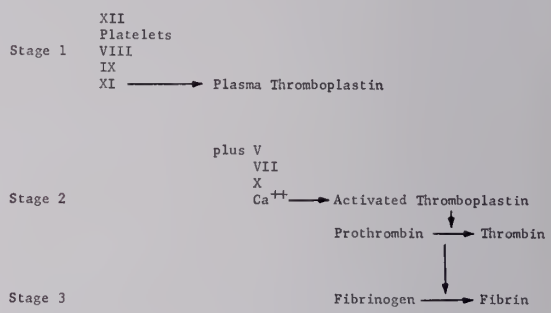


FIGURE 2. BLOOD COAGULATION, SIMPLIFIED

The Fibrinolytic System. The fibrinolytic system presents some similarities to the coagulation system (Fig. 3.) Here, too, an activator converts an inactive precursor, plasminogen, into a proteolytic enzyme, plasmin, which is capable of attacking not only fibrinogen but also fibrin and other proteins. And just as there are natural coagulation inhibitors, so there are plasmin and activator inhibitors.

Activators are normally present in only trace amounts in plasma but their level rises with a great variety of stimuli. These rises are usually physiologic and presumably protective to the organism but in conditions of marked overstimulation there may be varying degrees of proteolysis with potential for hemorrhage.

The Hemorrhagic Diseases

The hemorrhagic diseases may be outlined. (Fig. 4.) We have already mentioned that vascular deficiencies are usually only of contributory importance. The importance of the platelets, of course, cannot be overemphasized. Thrombocytopenia is relatively common and the bleeding may be severe. It may be idiopathic or secondary to toxic drugs, irradiation, bone marrow replacement by cancer, hypersplenism or many other causes. Infrequently

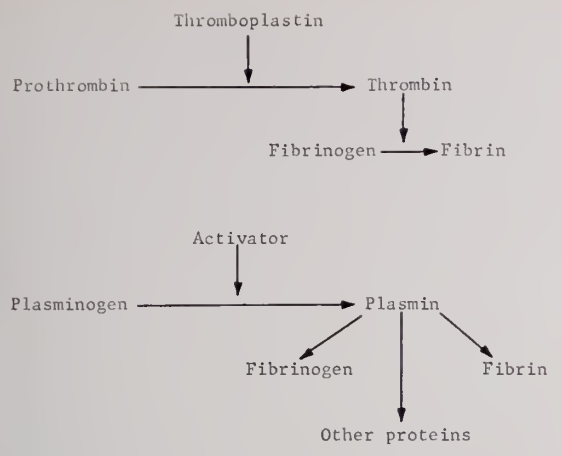


FIGURE 3. COAGULATION AND FIBRINOLYSIS COMPARED

there may be a qualitative defect of platelets and, rarely, an excessive number of platelets may cause a hemorrhagic tendency.

Defects in coagulation factors may be congenital or acquired. By far the most common variety of the congenital type is a defect in Factor VIII or classical hemophilia. Defects in Factors IX and XI cause hemophilic-like disease but are usually milder and easier to treat. Of some surgical importance is the probability that surgical stress may occasionally bring to light very mild forms of hemophilia.

The acquired coagulopathies should be of especial interest to the surgeon as they include the iatrogenic types. The hemorrhagic potential of the blood transfusion and dextran may not be fully appreciated. The transfusion reaction represents one form of the problem. On the operating table the only clinical sign may be generalized oozing. This oozing may be explained by the hemolysis which promotes clotting in the small vessels of the body. This intravascular clotting uses up platelets and Factors V and VIII, as well as prothrombin and fibrinogen, and stimulates fibrinolysis. It is

Angiopathies (Purpuras)

Thrombocytopenia and Thrombopathies

Coagulopathies
- **Congenital**
  - I, II, V, VII, VIII, IX, X, XI, XII
- **Acquired**
  - Drugs: Heparin, dicumarol, salicylates
  - Transfusion reaction, multiple transfusions, dextran
  - Hepatic disease
  - Pathologic fibrinolysis
  - Excessive consumption of coagulation factors by intravascular clotting or repeated hemostatic attempts

FIGURE 4. THE HEMORRHAGIC DISEASES

generally thought that the sudden severe thrombocytopenia is the predominant factor in the bleeding, although all the others may well play a part.

Multiple transfusions of bank blood involve repeated risk of reaction but carry a hemorrhagic potential in themselves. One group[8] of 108 patients received 5000 cc or more of blood each and one-third of this group developed a generalized hemorrhagic diathesis. In the same group every patient who received over 9000 cc of blood developed the hemorrhagic diathesis. The mechanism is controversial and the explanation may be complex. However, we know that bank blood is lacking in platelets and in coagulation Factors VIII and V. Excessive transfusion of bank blood may cause hemodilution of these elements. Other workers feel that degradation products of the bank blood are thromboplastic and may stimulate intravascular clotting and secondary fibrinolysis.

Dextran is a drug used in shock and for its antisludging properties in other situations. It may achieve its action, at least in part, by coating the platelets and interfering with their function. The same dose has a much greater effect on a patient with thrombocytopenia. Therefore, if given after multiple transfusions of bank blood it may potentiate bleeding. The dose of dextran is important, naturally, as is the molecular weight of the dextran. Some workers deny the threat of bleeding with the low molecular weight variety.

Hepatic disease is associated with defective hemostasis. Here the deficiencies are multicomponent and complex and which is the more critical in a given case may be hard to determine. All may be important, as multiple subclinical deficiencies are of more than mere additive significance. The prothrombin deficiency is well recognized, Factor V is frequently low, platelets are frequently low and abnormal in shape, fibrinogen may be low and fibrinolysis may be present.

Fibrinolysis is a physiologic protective mechanism but the system may be overstimulated. Excitement, stress, anoxia, various drugs and other factors associated with surgery may stimulate it. Certain tissues of the body (lung, uterus, prostate) are rich in activator and if manipulated such substances may be released. Certain chronic diseases, notably cirrhosis and cancer, are prone to be associated with per-

sistent high levels of activator. Operations involving extracorporeal apparatus, as in open heart surgery, are associated with great potential for fibrinolysis. When pathologic fibrinolysis does occur, bleeding involves not only the lysis of the formed clots but also destruction of protein coagulation factors. In addition, the lytic products of fibrin and fibrinogen have anticoagulant activity.

Repeated attempts at unsuccessful hemostasis or intravascular clotting may use up those coagulation factors consumed in production of a clot, notably platelets, Factors VIII and V, and fibrinogen and prothrombin. Intravascular clotting is a potent stimulus to fibrinolysis and the combination may understandably produce very severe hemorrhagic states.

Hemostatic Failure During Operation

To conclude, let us consider directly a patient who begins to bleed in alarming fashion at the operating table. It is perhaps trite but very important to emphasize that the first and foremost consideration is to rule out a surgical cause for the bleeding. Bleeding from a single area with the rest of the operative field dry is not apt to be due to a defect in the hemostatic mechanism.

Multiple sites of bleeding or a generalized ooze do suggest a hemostatic defect. The problem will be simplified if some thought has been given preoperatively to the possibility of abnormal bleeding. If a family and personal history has failed to elicit a bleeding tendency and if the physical has shown no overt sign of hemorrhagic diathesis, the only common defects we are apt to have missed are thrombocytopenia and mild hemophilia.

Therefore, preop laboratory evaluation should include an estimate of the platelets on the routine blood smear and in doubtful cases a platelet count. Minimal preop screening should also include a prothrombin time and probably a partial thromboplastin time. A bleeding time may discover a rare case of vascular purpura. Abnormalities of these tests may indicate hematologic consultation and possibly more complicated testing.

If we have essentially ruled out prior hematologic disease we may rationally assume we are faced with an acquired coagulation defect from probably a combination of mechanisms. The precipitating factor, or factors, may be of variable severity. The patient chronically depleted from malignancy, cirrhosis, or other long-term illness may have a marginal hemostatic reserve despite apparently normal hematologic testing. In these patients a relatively minor insult may lead to hemostatic decompensation.

As opposed to the specific defects of thrombocytopenia or hemophilia, we may assume that this patient will have multiple hemostatic defects. In some instances profuse bleeding may occur though no one defect seems sufficient alone to cause bleeding. We may also assume that the precipitating factor is transient. Therefore, if we sustain life and eliminate the precipitating factor or factors, there is likely to be spontaneous improvement in the hemostatic defect.

The urgency of the situation, the multiplicity of defects, the rapidly changing picture all mitigate against controlled laboratory studies. Platelets can be rapidly estimated and various studies of the clot may confirm severe defects fairly rapidly, but in many instances the clinical circumstances will best indicate the etiology of the bleeding.

Bleeding starting soon after a transfusion is begun is presumptive evidence of a transfusion reaction. Demonstration of agglutinated red cells or of free hemoglobin in the plasma will confirm the diagnosis. Stopping the transfusion and supporting blood volume and kidney function are the foremost considerations and hopefully the hematologic defect will spontaneously improve.

Bleeding beginning after multiple transfusions of bank blood entails the possibility of a reaction but also of dilution of platelets and other coagulation factors and of fibrinolysis. Fresh blood supports the blood volume and contains missing blood components. The use of one unit of fresh blood for every three or four of bank blood is a good prophylactic procedure in extensive operations.

While coagulation factors may be diluted during replacement of hemorrhage by bank blood, one or both of two other mechanisms may be even more significant in abnormal bleeding. Coagulation factors may be consumed by multiple hemostatic attempts in a

long bloody operation or by intravascular thrombosis or they, along with formed clots, may be lysed. The gravely ill patient is particularly susceptible both to thrombosis and to fibrinolysis from various causes. In a long difficult operation all three mechanisms—dilution, consumption and lysis—may be operative.

Fibrinolysis can be inhibited by epsilon aminocaproic acid (Amicar), a potent antiactivator, and this may occasionally be life saving. However, epsilon aminocaproic acid may be dangerous if the fibrinolysis is secondary to intravascular thrombosis. A severe depression of platelets would be a clue to thrombosis but we lack a thoroughly reliable test either on a practical or research basis.

If thrombosis is primary and the fibrinolysis secondary, improvement of the former should result in diminution of the latter. There are isolated reports in the literature of cessation of abnormal bleeding after giving heparin, and heparin alone or with epsilon aminocaproic acid has been recommended for treatment of combined thrombosis and fibrinolysis. In open heart surgery heparin is basic and addition of epsilon aminocaproic acid appears to reduce the incidence of abnormal bleeding. Therapeutic trial of heparin alone or with epsilon aminocaproic acid in most general surgery situations has been limited by the diagnostic difficulty, the relative rarity of abnormal bleeding and the natural fear that an anticoagulant will increase rather than decrease the troublesome bleeding.

Summary

Most bleeding at the operating table will not be due to a hemostatic defect. Occasionally, however, generalized oozing may indicate this to be the case. If our preoperative evaluation has indicated relatively normal hemostatic competence, the defect is likely related to dilution of coagulation factors by bank blood, to excessive consumption by extra- or intravascular clotting, to fibrinolysis or, most probably, to a combination of these mechanisms.

Discontinuance of the precipitating factors, if possible, and supportive therapy may result in spontaneous improvement. Fresh whole blood is the most readily available product that will both replace missing components and support blood volume. Epsilon aminocaproic acid will effectively reduce fibrinolysis. The possibility that intravascular thrombosis is the stimulus to the fibrinolysis is the most vexing problem both from practical therapeutic and research bases.

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Primary Intracranial Extradural Abscess Diagnosed by Carotid Angiography†

Horace A. Norrell, Jr., M.D.,* and Charles B. Wilson, M.D.**
Lexington, Kentucky

A case of primary frontal extradural abscess causing neurological deficit is presented. The theories of etiology and characteristic angiographic appearance are discussed.

INTRACRANIAL epidural abscess is uncommon in the absence of osteomyelitis of the skull or other intracranial infection. The purpose of the present report is to describe an intracranial epidural abscess of obscure origin in which the diagnosis was established by carotid angiography.

Case Report

A 45 year old housewife was admitted to a community hospital on 4-26-64. She had been well until three weeks earlier, when she developed an upper respiratory infection, followed shortly by headache, left earache, and pain in the posterior cervical region. Three days before admission to the hospital she became aphasic, and a mild right hemiparesis was noted. She had received no antibiotics. Examination on 4-26-64 revealed a temperature of 99.6°F., pulse 84, and blood pressure 95/60 mm. The patient had an expressive aphasia, with a right hemiparesis and obtundation. The left tympanic membrane was erythematous. Pertinent laboratory data revealed a white blood count of 21,300 with 86% polymorphonuclear leukocytes, a hemoglobin of 10.4 grams %, and a urinalysis which was normal. The following day she was less responsive and became incontinent of urine. A lumbar puncture was performed: opening pressure—260 mm. of water, cells—12 lymphocytes/mm^3, protein — 112 mg.%, glucose — 78 mg.%, and culture—no growth. Aqueous penicillin, chloramphenicol and streptomycin, in an adequate dosage, were administered beginning 4-27-64. Immediately following the lumbar puncture she had a focal motor seizure involving the right face and arm. She became unresponsive on 4-29-64 and was transferred to the University of Kentucky Hospital with a provisional diagnosis of left temporal lobe abscess.

Roentgenograms of the skull and sinuses were normal. Bilateral carotid angiograms demonstrated a 3 mm. contralateral displacement of the left anterior cerebral artery in the frontal view. (Figure 1) In the lateral view the frontal cortical veins terminated in the superior sagittal sinus, which was separated 1.6 cm. from the inner table of the skull as far posteriorly as the coronal suture. (Figure 2) This was interpreted as a mass within the extradural space. An aneurysm was seen arising from the



FIG. 1. The initial lateral phlebogram showing separation of the termination of the frontal cortical veins from the skull.

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FIG. 2. A half-axial projection of initial angiogram illustrating the shift of the anterior cerebral artery and aneurysm of the internal carotid artery.

supraclinoid portion of the left internal carotid artery.

Exploratory burr holes revealed one ounce of odorless creamy pus under pressure in the left frontal epidural space. A thin layer of pus was found overlying the right frontal dura. Systemic penicillin and Kanamycin were administered for five days following operation. Speech and the right hemiparesis recovered almost completely and the patient was discharged one week following surgery.

She was re-admitted on 6-17-64 (50 days following the original surgery) with expressive aphasia and right hemiparesis. A left carotid angiogram on 6-18-64 revealed displacement of the anterior cerebral artery 13 mm. to the right of the midline. In the lateral view the cortical vessels were not displaced from the inner table of the skull. Ventriculography demonstrated a parasagittal mass, and a subcortical encapsulated abscess contining 30 cc. of thick green pus was removed at operation. The capsule was loosely adherent to the frontal dura, but no communication could be found into the epidural space. Cultures from the abscess were sterile and no organisms were seen within the excised abscess capsule. The patient was able to speak and was walking with assistance when discharged 12 days following her last operation.

Successful intracranial clipping of the arterial aneurysm was accomplished 7-22-65. She is able to do her own housework and has a mild dysphasia under stress.

Discussion

The angiogram in this case was distinctive due to separation of cortical veins and the superior sagittal sinus from the inner table of the skull. An identical angiographic pattern may be produced by an epidural hematoma at the vertex.[1] Separation of the superficial cortical veins alone from the inner table of the skull may be produced by a subdural collection. However, displacement of the superior sagittal sinus is indicative of an epidural collection.[2] This is best visualized in the lateral phlebogram, which affords a tangential view of the course of the superior sagittal sinus and delineates the extent of the abscess. A tangential view obtained in the frontal projection would be useful to outline the lateral extent of the collection, although such a view was not obtained in this case.

The abscess in the present case occurred without an apparent primary source of infection. A review of the literature reveals only one other epidural abscess without a contiguous focus of infection.[3] Although our patient had acute otitis media on the original admission, the development of a frontal extradural abscess from this source is difficult to explain. Nielsen and Courville[4] reviewed the problem of frontal lobe brain abscesses secondary to ear disease. In none of their cases was the infection associated with an extradural abscess in the frontal area. They dismissed the bone and its diploic channels as the route of the infection. The extradural abscess reported here was apparently limited to the frontal parasagittal area. Most epidural abscesses are small and rarely produce brain compression with neurological symptoms.[5,6] Epidural abscesses may drain spontaneously beneath the scalp, or into the sinuses through a bony defect, clinical manifestations being limited to pain, tenderness and swelling about the area of involvement. The absence of a parenchymal mass on the original angiogram and the rapid recovery following surgical drainage of the epidural abscess suggest that the original neurological deficit in the present case was produced entirely by the epidural collection of pus.

Brunner[5] found epidural abscesses in association with 65% of the cerebral abscesses sec-

(Continued on page 1278)

Radiographic Contributions to Organ Transplantation†

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Significant information in the field of organ transplantation is provided by currently available radiographic technics. Such information is applicable to diagnosis, management prior to transplantation and follow-up control and evaluation, as well as experimental research.

RADIATION therapy is recognized as an adjunct in the preparation of a patient for organ transplantation, and as a potent agent in the management of threatened graft rejection. This presentation, however, will be limited to a consideration of *diagnostic radiology* and its role in this rapidly expanding field of medical endeavor. It will be limited further by the fact that my personal experience in this area has been restricted to transplantation procedures in children. This is not necessarily disadvantageous. Children may constitute the most favorable group as candidates for organ transplantation because the failing organ is more likely than in adults to be one congenitally malformed in an otherwise intact individual. The results of transplantation procedures in adults may be compromised or adversely affected because of associated abnormalities such as vascular alterations or other evidence of degenerative disease. However, what I have to say may be applicable to adults as well as children.

Radiographic functions can be subdivided into three main areas:

I Diagnosis
II Management prior to transplantation
III Follow-up control and evaluation

Let us consider them in sequence.

Diagnosis

The nature and extent of the primary disease for which transplantation becomes necessary are usually evaluated in part by radiographic examination. In addition, radiologic technics may uncover abnormalities known to be associated with the condition for which transplantation is being considered. Furthermore, unsuspected conditions which may have a bearing on the suitability of the patient for the procedure, or on the procedure itself, may be discovered.

There is no limit to the procedures used for diagnosis. The child with a severe lye stricture of the esophagus may have his disease evaluated by *barium esophagram,* and an unsuspected malrotation which is found and confirmed by *barium enema* is important for the surgeon who plans to undertake a colonic transplantation autograft. Valvular insufficiency in the heart can be documented with clarity on *opaque vascular studies* and thus set the stage for allograft or heterograft procedures. Failing kidneys may be shown by *excretory* or *retrograde studies* to be secondary to lower urinary tract obstruction or malformation, and therefore capable of recovery following urinary diversion into a homograft of an ileal loop. *Simple fluoroscopy* can be used as a guide to renal biopsy in other instances of renal failure to evaluate the potential candidate for renal transplantation. *Special diagnostic procedures,* such as arteriography, can define vascular causes for hypertension, which may require organ removal and transplantation.

The first transplantation as such I can remember was an attempt to save an extremity in a girl with a bone neoplasm at the upper end of the humerus. The distal expanded portion in the elbow joint was retained and a piece of tibia of appropriate length was re-

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FIGURE 1. Aortogram in 14½ year old boy with uremia due to chronic nephritis in hypoplastic kidneys. Note small size of renal arteries (arrows); they are usually similar in size to the splenic and hepatic arteries above them. Compare with Figure 2.

moved and re-inserted in place of the resected proximal three-fourths of the humerus. The resulting extremity functioned for six months when local recurrence in the soft tissues made necessary fore-quarter amputation. In this patient, simple skeletal radiographs provided information for the diagnosis and management.

All the procedures noted above, and many others, are practically routine in any department of diagnostic radiology and available to the physician whose patient may be a candidate for an organ transplantation.

Management Prior To Transplantation

Because the greatest experience has been reported in renal transplantation, major emphasis will be in relation to renal radiography. In renal transplantation, arteriographic procedures are necessary for both patient and donor. In the patient, they usually have been part of the diagnostic study (Figure 1); but I can imagine their values in an instance of unsuspected anomaly of the iliac vessels which may have a bearing on the side of election for receipt of an allograft.

In the donor, aortography demonstrates the presence of the necessary two normal kidneys, and in particular, the anatomy of the vascular supply. (Figure 2) A kidney with more than one renal artery is not a good kidney to transplant as the extra time required for the vascular anastomosis increases the time that the organ must remain ischemic. Aortography of recipient and donor prior to surgery may thus save precious moments of renal ischemia.

Knowledge of the pre-transplantation anatomy of the renal vessels (and of the pelvis and ureter) is necessary to evaluate impending rejection, or other complications — e.g., strictures and obstructions — after transplantation.

One can anticipate that as transplantations of other organs become more feasible, demonstration of the vascular anatomy both arterial and venous may be of considerable importance to the surgeon undertaking the procedure.

Clinically silent complications to the immuno-suppressive agents used for preparation of a graft recipient may be found by radiographic examination of the chest, etc. (e.g.: pneumonia) and appropriate measures taken in time to prevent a catastrophic reaction.



FIGURE 2. Aortogram in mother of patient during evaluation as potential donor for renal transplant. There are two normal kidneys, each with a single renal artery of normal size.

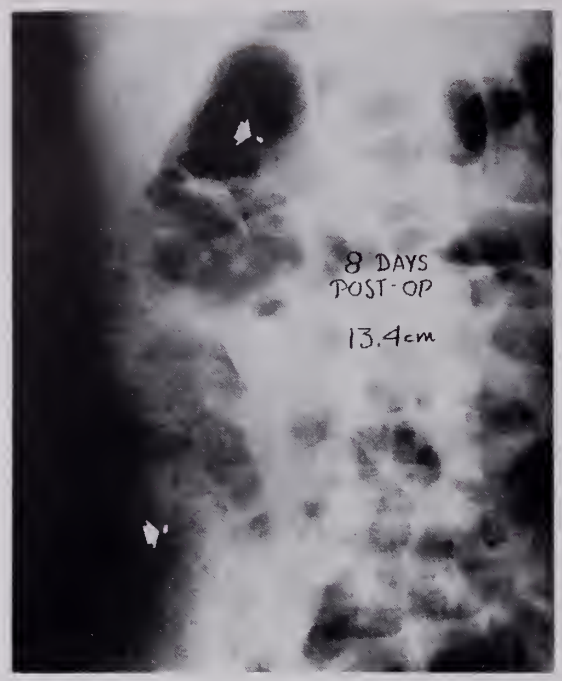


FIGURE 3. Post-transplantation film. The size of the transplanted kidney is easily followed by measurements of the distance between metallic clips (arrows) placed at the upper and lower poles at the time of surgery.

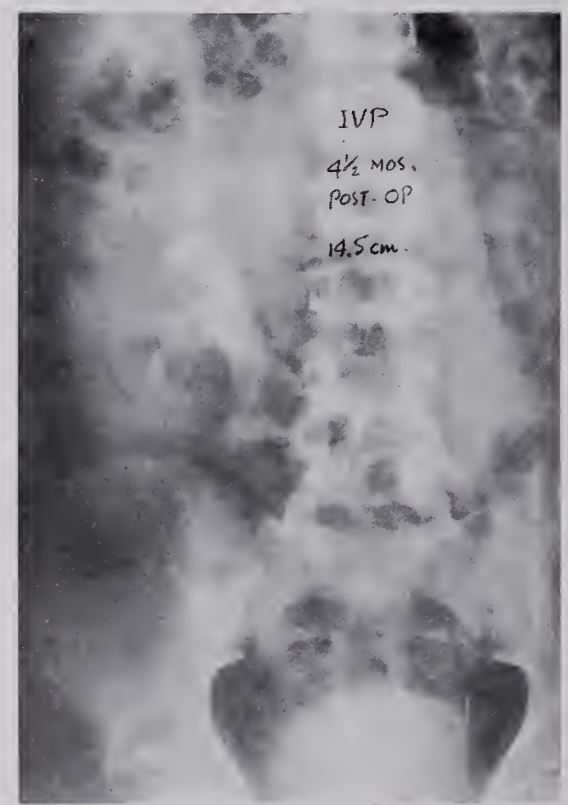


FIGURE 4. Same patient, 4½ months after transplantation. The transplanted kidney has increased in size; its pelvis is slightly dilated but drainage into the bladder excludes obstruction. The kidney functions well.

Follow-Up Studies

At the time of transplantation, metallic clips can be attached to opposite poles of the kidney. (Figure 3) Measurement of the distance between them on abdominal films at the completion of the procedure provides a base line for recognition of subsequent rejection phenomena, and the response to its management. Growth or hypertrophy can be followed in successful grafts by the same method. Care is taken to duplicate position and distance factors in exposures to minimize distortion due to magnification.

Complications other than rejection can be evaluated by post operative intravenous pyelograms. Obstructive complications such as stricture might present as progressive dilatation.

We have been interested to note pelvic and ureteral dilatation several weeks after surgery which contrasts with the normal pattern seen shortly after surgery. (Figure 4) Follow-up examinations up to two years show no progression and no recovery. (Figures 5 and 6) Could this be a neurogenic complication? Ureteral action is primarily an example of a simple stretch reflex in smooth muscle, but tone may be maintained by superimposed neural influences. Such influences obviously are disrupted by the transplantation procedure. Disturbance of lymphatic drainage also may play a role in this change.

Recently Alfidi and his associates[1] at Cleveland reported the use of selective angiography in the evaluation of persistent anuria or oliguria after renal homotransplantation. They were able to identify three instances of renal artery thrombosis, one of renal vein thrombosis, and in three, evidence of the rejection phenomenon. They were also able to describe the pattern of vessels in normally functioning homografts which are appreciably different from those in pre-transplantation examinations. Edema caused stretching and attenuation of the intrarenal arteries, although filling was regular and extended to the arcuate arteries; in the nephrographic phase, the arteries were emptied and a uniform nephrogram was obtained as prior to transplantation.

Renal artery thrombosis was readily recognized by obliteration of the lumen of this vessel and failure to fill the intrarenal branches. Renal vein thrombosis was characterized by



FIGURE 5. Eight year old male. IVP two weeks after renal transplant from mother donor. Excellent function of the transplated kidney. The metallic clips have lost their attachment to the poles of the kidney and are no longer useful for evaluation of kidney size.



FIGURE 6. Same patient as in Figure 5. IVP six months after transplantation. The pelvocaliceal dilatation has now persisted with little further change for two years and three months at time of last examination. Clinically well.

persistence of contrast material in the arteries, poor filling of peripheral arteries, and a poor nephrographic phase. Retrograde renal vein catheterization subsequently revealed the thrombus.

Rejection was indicated by similar arterial and nephrographic features with, however, a patent renal artery and renal vein. Only 20 transplants were studied and additional studies are necessary to confirm the findings, but here is an important contribution which can be made by the radiologist in the follow-up management of patients with renal transplantation. The recent innovation of an indwelling catheter in the graft renal artery via the iliac artery[4] makes easier high dosage of immuno-suppressive drugs in the kidney, but also provides an avenue for arteriography making this procedure a less strenuous one. A similar catheter in the renal vein might simplify contrast visuali-

(Continued on page 1279)

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after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.



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Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

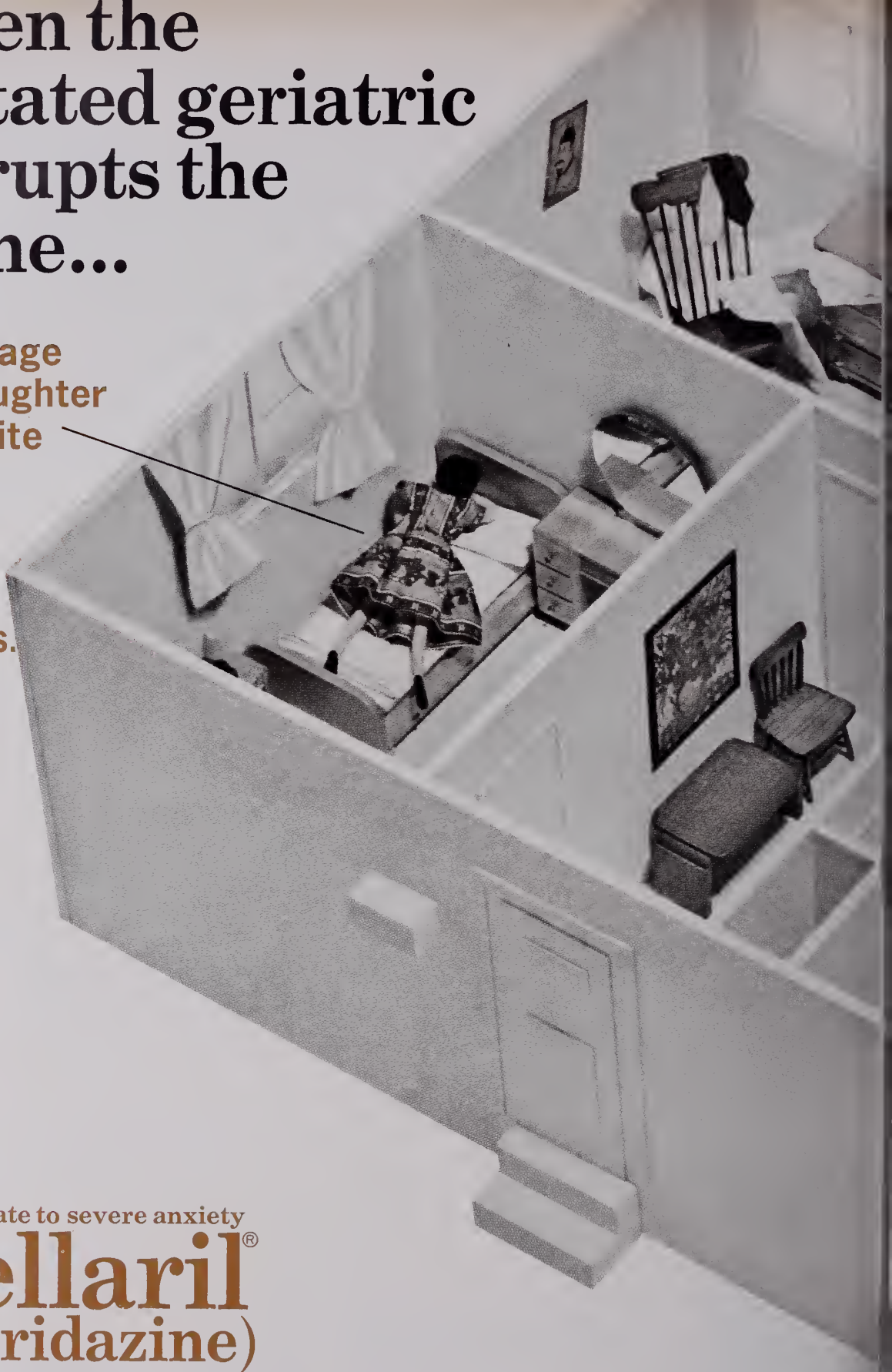
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When the agitated geriatric disrupts the home...

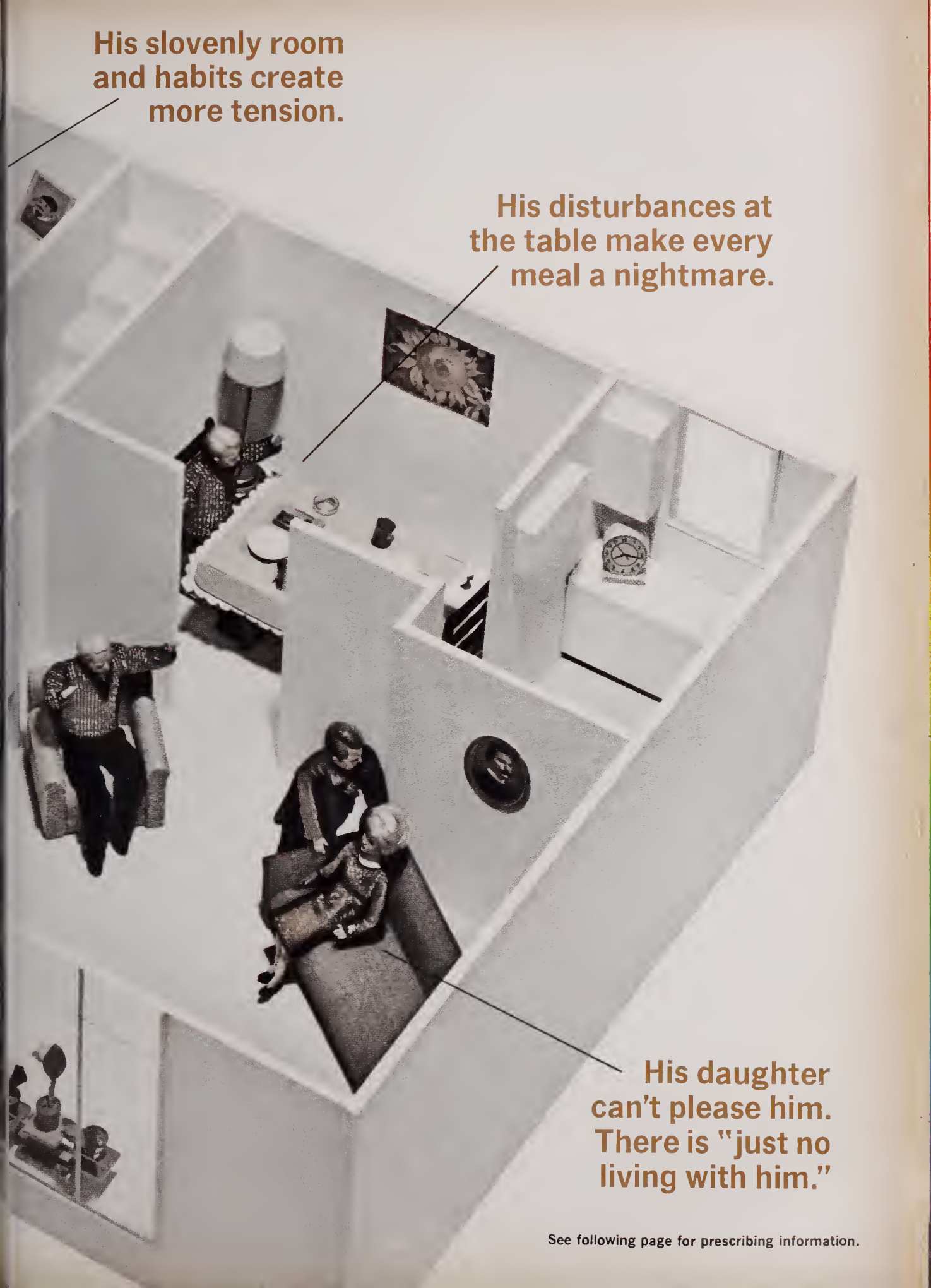
His teen-age granddaughter won't invite friends home because of his outbursts.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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SPECIAL ARTICLES

The Education of Ministers in the Care of the Sick†

WAYNE E. OATES, Th.D.*

AS ONE medical doctor has said, "a new breed of ministers is coming from theological schools today." They know what they are doing when they visit the sick. They know how to collaborate with the doctor. To collaborate with the doctor, the nurse, and the family of a patient and to encourage the processes of health in the patient are the intentions of the trained minister. Yet training of a clinical, bed-side variety is necessary to produce this kind of minister. The purpose of this article is to describe factually what this training of the minister is like. I speak from the perspective of the curriculum of the Department of Psychology of Religion and Pastoral Care of The Southern Baptist Theological Seminary where I have worked for 22 years. However, the programs of other seminaries in Kentucky and in the country as a whole are similar to what is done at this school.

Basic Training

The basic training of the theological student for general parish ministry to the sick includes the following. He is required to master certain hard facts and tested procedures. He is expected to know how to define his own identity and area of competence as a representative of God. For example, he cannot be timid or brash about being an authority on the teachings of the Bible and of his church. No crippling sense of unfavorable comparison can hinder him from actually working as a member of the team of other persons who help the sick—doctors, nurses, social workers, etc. The minister is expected to learn the arts of observation, inspection, and evaluation of persons not yet under a doctor's care, as well as those already in treatment. We teach him the use of a *clinical* method of studying both those problems of others presented to him and his own reactions to them. He is expected to know the resources of the community for referral of people in need of specialized attention of physicians, social workers, psychologists, etc. He is expected to know how to handle the varied forms of his relationship as a pastor—in that he is friend, neighbor, pastor, etc.—and use all of these relationships to the best advantage of the people whom he serves.

Furthermore, the basic training of the student introduces him to the crisis ministry of the pastor. This ministry includes three kinds of crises: (1) Catastrophic crises, such as war, depression, epidemic, flood, fire, and other kinds of disaster; (2) Emergency crises such as individual and family experience—the ministry to the dying, the ministry to surgical patients, the ministry to accident victims, the ministry to the family facing divorce, the ministry to the family of the acute alcoholic situation, etc.; and (3) The third kind of crisis is more subtle: the developmental crises —the birth of a child, the time of a wedding, the beginning of the school years, the time of the departure of the last child from the home, the event of retirement, etc. Here the trained eye spots the beginnings of trouble.

The basic training of the minister puts students in classes of about 30 in number. The classes use about 128 hours of classroom instruction. We involve the student in an "externe" field work situation. We usually place them in small pastorates, as assistants to more experienced ministers, as assistants to chaplains of hospitals, and in a few personnel departments of Louisville industries. They usually get, over the period of their education, about 400 hours of supervised clinical exposure in these projects. We call this "field education" under supervision.

Elective Work

Such basic training is required of all theological student groups. It provides the prerequisite work for elective work students take in the normal course of their Master of Divinity degree. At the elective level they may take several practicum courses. One of these is in marriage and family counseling. Well over 60 percent of the problems that come to the pastor's attention as a pastor center around marital conflict and parental conflict. Occasionally these conflicts involve religious differences. Ordinarily the pastor's counseling seeks to implement the agreed upon religion of the couple at the very personal level of reconciliation, forgiveness, and maturation of love required by any religion worth the name.

A second area of elective work available to students is psychiatric information for ministers. Much of this amounts to straight medical information such as a

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†Presented at a September 27, 1967, meeting of the KMA Committee on Medicine and Religion who requested its publication in The Journal.

**Director of Pastoral Training, Southern Baptist Theological Seminary, Louisville*

social worker would need. This practicum is aimed to enable the student to evaluate a clinical situation much as a medical aide in the army would render first aid and conduct a holding action until specialized medical care can be gotten. We do this under medical and nursing auspices with the staff at the Norton Psychiatric Unit where our students for eight weeks give 24 hours a week to an orientation course conducted by the staff there. Considerable attention is given to the religious factors in mental illness.

A senior level of undergraduate instruction is conducted completely within two hospital settings—the Medical Center under the supervision of its chaplains, and Central Hospital under the supervision of its chaplains. These chaplains hold clinical appointments as clinical professors on our faculty. The student spends a rotating internship on a halftime basis with his class work during the 32 weeks of the fall and spring semesters. Or, he can work on a full time basis during the summers. He is not paid for this. However, he functions in the capacity of an assistant chaplain. He attends lectures by the chaplains, members of the hospital staff and others. He participates in case conferences based on notes that he has made concerning his work with patients. He has at least one or more supervisory interviews per week with his supervisor. We have a ratio of one to five between supervisors and students. Training as a supervisor is a part of graduate residency work. Such men must have already been through the basic clinical training before they qualify to apply for graduate work. Finally the student attends a group interaction seminar designed to enable him to work cooperatively with other ministers. We do not find nearly the difficulty in working with other professions that we find working within our own. This we try to "get at" in these group interaction seminars.

Specialization

Some students choose to specialize in pastoral care at the graduate level. Our undergraduate work requires a four year college degree as a prerequisite. Our graduate work on the Doctorate in Theology requires the Master of Divinity degree as a prerequisite, which is three years beyond college. The Doctorate in Theology is three to four years beyond the Master of Divinity. The student usually spends about half of his doctoral studies in intensive clinical work. The focus of his learning here is teaching and research. For example, this year we have graduated three such students. One of them did a controlled study of 30 middle adolescents' religious experiences in an inner city church. One of them used extensive research designs in studying the attitudes of selected students in clinical pastoral education toward authority and its use. The other has studied the kinds of ministries indicated in the care of families at the time of the birth of a baby. The latter study involved 20 families who have born a new baby within the last year.

Clinical Pastoral Visitation

So much for the group instruction and individual supervision. The preponderant majority of the student's time is spent in ward visitation, bedside conversation with the patients, conversation with members of the family of the patient who is seriously ill or in surgery, the care and comfort of the family of the terminally ill and the deceased, etc. This care takes on different forms at differing levels of seriousness.

We assume that there are several kinds of visits: (1) the "hello" visit to get acquainted, to offer one's services, to fulfill a promise to a family member, to interrupt the boredom and monotony of convalescence, etc.; (2) the brief social visit to persons who may already have a pastor, who may be of another faith, etc.; (3) the preoperative visit on the night before an operation—not the morning of the operation; (4) the supportive visit for a patient discouraged in his progress or lack of progress toward recovery; (5) the "problem interview" visit, such as the instance of a patient who may have problems "external" to, but influential upon, the course of the illness—for example, the patient who is insecure in his religious faith as he faces surgery, the patient who has need of confession, a patient who may be weighed down with fear that his marital partner will divorce him while in the hospital, etc.; (6) the longer term, spiritual enquiry relationship, such as that with a tubercular patient who knows his situation, or that of a depressed person who feels unrealistic emotions of self-condemnation for seemingly unimportant acts, etc.; and (7) the ministry to the staff member who loses a patient by death after a long battle with disease in their patient—the nurse and the doctor.

These kinds of visitation and more tend to form the substance of the work the student is taught to do. In addition to visitation, the student is taught the ministry of prayer with individual patients, the careful prescription rather than the patent medicine approach of the right kind of scripture with patients, the leadership of informal and formal worship services for ambulatory patients in the chapel setting. In the hospital at Central State the student is literally the pastor of a given ward. He has communion services, he leads groups of patients in Bible study, he preaches in the chapel. He does all these things in close communication with the staff of the hospital and espcially the chaplain. The chaplain is a member of the staff there. He attends the staff meetings. This is more necessary with psychiatric patients, but is also helpful with medical patients.

We work very hard at the business of not reduplicating the work of the parish minister of the patient. If the patient has a parish minister, then the task of the chaplain is to put them in contact with each other and undergird the efforts of the parish minister. We have Catholic and Jewish chaplains at both these centers, and care is taken that an effective relationship is maintained with them in meeting the needs of persons of other than one's own faith group. The model of cooperation set in the Armed Forces had been the pattern here.

We do not teach students to proselytize patients. We teach them to be an effective part of the patient's recovery with the resources of religion. We teach him to minister to the person in such a way that when he is well he can make his own decisions about his religious affiliation. We think there is something de-

(Continued on page 1279)

EDITORIALS

A Thank You

AT THIS present time many large industrial companies and governmental agencies carry on their operations by a regional type of organizational structure which may have little regard for state boundaries. State boundaries do remain, however, not only as geographical lines but in a political and, in many instances, an organizational sense.

So it is that the Kentucky Medical Association serves a unique and necessary purpose among all the many medical organizations that exist today. So it is that The Journal of the KMA serves a necessary and unique purpose among the many medical journals that are published today.

This Christmas season is the sixty-fifth for The Journal and it again is an opportunity for the editors to express their appreciation to all the many people who have supported The Journal in their special but different ways during the past year. We express our thanks to those who prepared scientific and special articles. Our thanks goes to the deans and respective faculties of the medical schools of the University of Louisville and University of Kentucky for the support and cooperation that we have always received from them.

We are grateful to the physicians who serve as scientific consultants.

A special thanks to the companies that have chosen to advertise in the pages of The Journal during this past year. It is from them that The Journal receives much of its financial support.

To all of these our thanks and our best wishes for a Merry Christmas and a Happy New Year.

WALTER S. COE, M.D.

Brand or Generic Prescriptions

A PHYSICIAN prepares to write a prescription for a patient and the patient asks, "Can you write one of those generic ones so I can get it cheaper?" This question or similar ones do occur these days. What is the best and most accurate answer to such a question? But first, what about this word "generic"? Everyone understands the phrase "brand name" but the word "generic" is not as widely understood by the public. It would seem that this represents a poor use of the word to describe specific chemical compounds.

In a non-biological sense, the word "generic" means general; the opposite of specific. In a biological sense, the word "generic" pertains to having the rank of a genus which is a group of structurally or phylogenetically related species. The use of the word "generic" to indicate the chemical name of compounds has added to the confusion but we seem to be stuck with it.

It is evident that prescribing a drug by its generic or chemical name gives the pharmacist a wider latitude in selecting the specific source of the drug to be used in filling the individual prescription. The question at this point would be whether the same drug obtained from different sources would in all instances be therapeutically equivalent.

James Goddard, M.D., Commissioner of the Food and Drug Administration, stated in March of this year that we didn't know this to be true at the present time. He indicated at that time that the Food and Drug Administration had started a pilot project in St. Louis which might lead to the establishment of a National Drug Testing Center. The purpose of this center would be to make certain that all drugs are therapeutically active and potent as indicated in the physician's prescription.

At the present time when a physician writes a prescription using a generic term he has no definite idea as to who the manufacturer of the drug will be or what the standards of that particular company are. Can we expect the busy pharmacist to be familiar with the standards of all the many companies that manufacture drugs? It is the physician who has the ultimate responsibility for the treatment of the patient and he needs to be as aware as possible of the drug products prescribed and dispensed for his patients.

In Washington, hearings were recently held by the Senate Finance Committee on a bill (S.2299) sponsored by Senator Russell Long. The Long Bill would establish a National Formulary to list drugs for which the federal government would reimburse welfare patients. Commissioner Goddard expressed opposition to the bill and indicated it would result in an encroachment on the practice of medicine in such a way that physicians in the country would resent it. He also indicated that it would take the F.D.A. at least three years before they could assure complete reliability of all drugs on the market. This latter kind of information would certainly encourage physicians to prescribe drugs from a manufacturing source in which they have confidence.

Recent findings by Parke-Davis that a generic chloramphenicol failed to produce the same therapeutic effect as the company's brand name Chloromycetin would seem to have significance. The point of this experiment is that the generic equivalent of Chloromycetin that was reported as tested had the same chemical structure as the brand name product; both products are reported as meeting the standards set by F.D.A. The F.D.A. is apparently examining the Parke-Davis data and conducting studies of its own. If the Parke-Davis tests are confirmed, the results would suggest that laboratory tests alone are not sufficient to judge what a drug is going to do in the body and that the formulation of a drug could influence the therapeutic effect.

Much has been said and written in the past year regarding generic or brand name prescriptions. However, after reviewing some of the available information, it would appear that the policy stated in November, 1966, by the AMA House of Delegates is a good one and needs no change at the present time. That policy statement was to the effect that physicians should be free to prescribe drugs generically or by brand name for all their patients, whether they are private, Medicare, or indigent patient, the primary consideration being the best interests of the patient.

WALTER S. COE, M.D.

May Your Holiday Season Be Filled With Happiness

Walter S. Coe, M.D., Editor
and the
Journal Staff

*Lead, Kindly Light**

Cardinal John Henry Newman

Lead, kindly Light, amid th' encircling gloom,
Lead Thou me on!
The night is dark, and I am far from home;
Lead Thou me on!
Keep Thou my feet;
I do not ask to see
The distant scene—
One step enough for me.

I was not ever thus, nor prayed that
Thou Shouldst lead me on;
I loved to choose and see my path; but now
Lead Thou me on!
I loved the garish day,
And, spite of fears,
Pride ruled my will:
Remember not past years.

So long Thy power hath blest me, sure it still
Will lead me on,
O'er moor and fen, o'er crag and torrent, till
The night is gone,
And with the morn
Those angel faces smile;
Which I have loved long since,
And lost awhile!

**This tribute is printed in memory of the 58 Kentucky physicians who died during the past year. The following page carries the complete list.*

Deceased Kentucky Physicians

1967*

Ernest William Akins, Louisville
Henry B. Allen, Lexington
William G. Birchett, Louisville
Henry H. Bunch, Williamsburg
James W. Bruce, Louisville
J. Randolph Buskirk, Louisville
Edwin Cameron, Clay City
John D. Carpenter, Louisville
Misch Casper, Louisville
Jack L. Chumley, Louisville
Jerome E. Cohn, Lexington
Bertis N. Comer, Falmouth
Jay C. Coulter, Mayfield
James F. Crane, Sarasota, Fla.
Marion O. Crowder, Owensboro
George F. Doyle, Winchester
Charles M. Edelen, Louisville
Louis M. Foltz, Louisville
Harold Gordon, Louisville
Guthrie Y. Graves, Bowling Green
Guy Parham Grigsby, Louisville
Alphonso F. Guiglia, Louisville
Lewis C. Hafer, Florence
James A. Harris, Paducah
Clifford N. Heisel, Newport
George F. Jones, Henderson
David Y. Keith, Jr., Paducah
John L. Kendall, Sarasota, Fla.
Joseph F. Laine, Louisville
Clarence H. Likins, Jr., Louisville
Charles F. Long, Elizabethtown
Alfred Mathys, Louisville
Oscar L. May, Danville
William R. McMillen, Covington
Thomas O. Meredith, Harrodsburg
Herman H. Morgan, Maysville
Edward J. Murray, Lexington
Hershell B. Murray, West Liberty
David R. Nagel, Lexington
Carl Norfleet, Somerset
Edgar W. Northcutt, Covington
Samuel B. Nunnelly, Hebron
Oliver H. P. Parrigan, Monticello
Milton Miller Phillips, Crab Orchard
Syre L. Polk, Paducah
Richard C. Porter, Louisville
Frank M. Powell, Louisville
Otway W. Rash, Owensboro
Benjamin F. Reynolds, Carlisle
C. M. Rice, Owensboro
Paul F. Rizk, Grayson
Elmer R. Smith, Somerset
L. E. Smith, Calvert City
Lillian H. South, Louisville
Robert G. Spurling, Louisville
Joseph A. Stoeckinger, Lexington
Charles O. Tydings, Fern Creek
B. F. Workman, Brooksville

**List of names of deceased physicians available to The Journal as of November 20, 1967.*

The W. H. Wathen Memorial Meeting Of The Kentucky Medical Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 25-28, 1967

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Richard F. Greathouse, M.D., Louisville

Speaker of the House, Presiding

First Session

Doctor Greathouse called the meeting to order and asked Paul Parks, M.D., Bowling Green, Chairman of the Council on Governmental Medical Services, to give the invocation. C. J. Brueggemann, M. D., Covington, Chairman of the Credentials Committee, reported that a quorum was present. A motion was made and seconded to approve the Minutes of the 1966 session of the House of Delegates as published in the December 1966 issue of The Journal of the Kentucky Medical Association. The motion carried.

Henry B. Asman, M. D., KMA Secretary, presented the general announcements. The Secretary reported that the President's Luncheon speaker would be Nicholas Dallis, M. D., Scottsdale, Arizona. Doctor Asman pointed out that the seven reference committees would convene for their sessions at 2:00 p.m., Monday, on the mezzanine floor of the Kentucky Hotel. On Tuesday, September 26, at 8:50 a.m., the opening scientific session was to begin in the Convention Center.

The Secretary then read the list of physicians who had passed away since the 1966 meeting of the House of Delegates. The members of the House stood for a moment of silent tribute. The names of the physicians, their locations and dates of death are as follows:

Allen, Henry B. (Emeritus)	Lexington	March 29, 1967
Birchett, William G.	Louisville	Oct. 2, 1966
Bradley, George (Member)	Elizabethtown	Sept. 1966
Bruce, James W. (Emeritus)	Louisville	March 2, 1967
Brumback, Kenneth W. (Member)	Cynthiana	Sept. 1966
Bunch, Henry H. (Member)	Williamsburg	Aug. 6, 1967
Buskirk, J. Randolph (Member)	Louisville	Aug. 29, 1967
Cameron, Edwin	Clay City	April 6, 1967
Carpenter, John D.	Louisville	Feb. 18, 1967
Casper, Misch M. (Emeritus)	Louisville	March 17, 1967
Chumley, Jack L. (Member)	Louisville	March 11, 1967
Cohn, Jerome E.	Lexington	April 3, 1967
Comer, Bertis N. (Emeritus)	Falmouth	Dec. 15, 1966
Crowder, Marion O. (Member)	Owensboro	July 22, 1967
Doyle, George F. (Emeritus)	Winchester	March 22, 1967
Edelen, Charles M. (Member)	Louisville	April 11, 1967
Flowers, Woodruff J. (Emeritus)	Columbia	August 1966
Foltz, Louis M. (Member)	Louisville	Jan. 15, 1967
Gordon, Harold (Emeritus)	Louisville	April 19, 1967
Graves, Guthrie Y. (Member)	Bowling Green	May 1967
Guiglia, Alphonso F.	Louisville	Nov. 10, 1966
Hafer, Lewis C. (Emeritus)	Hebron	March 25, 1967
Harris, James A. (Member)	Paducah	Jan. 5, 1967
Heisel, Clifford N. (Emeritus)	Covington	May 27, 1967
Johnson, Henry V. (Emeritus)	Georgetown	Oct. 9, 1966
Jones, George F. (Emeritus)	Henderson	Aug. 10, 1966
Keith, David Y. Jr. (Member)	Paducah	June 24, 1967
Likins, C. H. Jr. (Member)	Louisville	Aug. 6, 1967
Long, Charles F. (Member)	Elizabethtown	Nov. 8, 1966
May, Oscar L.	Danville	June 6, 1967
McMillen, William R.	Covington	Oct. 13, 1966
Murray, Edward J. (Emeritus)	Lexington	Nov. 1966
Murray, Hershell B. (Member)	West Liberty	May 21, 1967
Nagel, David R. (Member)	Lexington	March 29, 1967
Nichols, Clyde J. (Member)	Clarkson	July, 1967
Norfleet, Carl (Emeritus)	Somerset	Oct. 1966
Northcutt, Edgar W. (Emeritus)	Covington	Jan. 1, 1967
Nunnelly, Samuel B. (Emeritus)	Hebron	Aug. 1967
Polk, Syre L.	Paducah	March 7, 1967

Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of the proceedings, may come to the Headquarters Office and listen to the recording.

Powell, Frank M.	Louisville	Dec. 5, 1966
Rash, Otway W. (Emeritus)	Owensboro	Nov. 22, 1966
Reynolds, Benjamin F. (Emeritus)	Carlisle	April 10, 1967
Rice, C. M. (Emeritus)	Owensboro	Jan. 22, 1967
Salyers, John O.	Louisville	Sept. 18, 1966
Smith, Elmer R. (Member)	Somerset	Sept. 1966
Smith, L. E.	Calvert City	Dec. 28, 1966
South, Lillian H. (Emeritus)	Louisville	Sept. 14, 1966
Spurling, Robert G. (Member)	Louisville	April 7, 1967
Stoeckinger, Joseph A. (Member)	Lexington	Dec. 15, 1966
Workman, B. F.	Brooksville	April 17, 1967
Yelton, Emery J.	Germantown	Oct. 20, 1966

Following the announcements, Doctor Greathouse brought out the fact that a problem heretofore not experienced had arisen. A member of the Nominating Committee was unable to be present for this meeting. The Speaker called on Mr. E. Gaines Davis, attorney for the Association, for a ruling on this matter. Mr. Davis explained that the House of Delegates has the authority to name a replacement for the absent member of the Nominating Committee. Following this explanation, Doctor Greathouse suggested to the members the name of Guy Cunningham, M. D., Ashland, as a member of the 1967 Nominating Committee. A motion was made, seconded and passed that Doctor Cunningham serve on the Nominating Committee.

The Speaker announced the reference committee appointments as follows:

Reference Committee No.1 — Reports of Officers and Board of Trustees

C. Melvin Bernhard, M.D., Louisville, Chairman
John F. Berry, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hyden
Thomas L. Heavern, M.D., Highland Heights
R. J. Phillips, M.D., Owensboro

Reference Committee No. 2 — Scientific Assembly and Medical Education

Eugene H. Conner, M.D., Louisville, Chairman
C. C. Lowry, M.D., Murray
R. J. Salisbury, M.D., Mt. Sterling
Ralph G. Thomas, M.D., Leitchfield
Marion A. Douglas, M.D., LaRue

Reference Committee No. 3 — Legislative Activities

David A. Hull, M.D., Lexington, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
Clyde T. Moore, M.D., Fern Creek
Norma Shepherd, M.D., Hopkinsville

Reference Committee No. 4 — Public Service and Medical Services

W. Fielding Rubel, M.D., Louisville, Chairman
W. E. Becknell, M.D., Manchester
Kenneth M. Eblen, M.D., Henderson
Robert Robbins, M.D., Greenville
James B. Tolliver, M.D., Whitesburg

Reference Committee No. 5 — Governmental Medical Service

Andrew M. Moore, M.D., Lexington, Chairman
James L. Ferrell, M.D., Paris
Walter Johnson, M.D., Paducah
Robert E. Norsworthy, M.D., Hartford
William M. Wyatt, M.D., Somerset

Reference Committee No. 6 — Constitution and Bylaws; Special Committees

W. Vinson Pierce, M.D., Covington, Chairman
John M. Baird, M.D., Danville
N. Lewis Bosworth, M.D., Lexington
Robert L. McClendon, M.D., Louisville
Dixie Snider, M.D., Springfield

Reference Committee No. 7 — Miscellaneous

Harvey A. Page, M.D., Pikeville, Chairman
James Holbrook, M.D., Prestonsburg
James G. Sills, M.D., Hardinsburg
Loman C. Trover, M.D., Madisonville
Donald Varga, M.D., Louisville

The Speaker reported the tellers for the meeting would be Sanford Weiler, M.D., Frankfort, Chairman; Max Wheeler, M.D., Ashland; and Luther Wilson, M.D., Bowling Green.

At this time, the reports of the officers and committees were presented and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President, Woman's Auxiliary to KMA—Reference Committee No. 1

After the presentation of this report, the following motion was made, seconded and carried: that KMA hereby acknowledge the dedicated industry of its Woman's Auxiliary and commend that Auxiliary for its many fine services both to the Commonwealth of Kentucky and the Kentucky Medical Association.

Report of President-Elect—Reference Committee No. 1

Report of Speaker of House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1 with the following exceptions: Supplemental Report A, referred to Reference Committee No. 6; Supplemental Reports B and C, referred to Reference Committee No. 5.

Doctor Greathouse then recognized Richard F. Grise, M.D., Bowling Green, Chairman of the Awards Committee, for his nominations for the Distinguished Service Medal and the Outstanding General Practitioner Award. Clyde C. Sparks, M.D., Ashland, was nominated for the Distinguished Service Medal. The name of William Harrison Jones, M.D., Gray, was placed in nomination for the Outstanding General Practitioner Award. A motion was made, seconded, and carried to accept these two nominations.

The House adjourned at this point for a coffee break provided by the Kentucky State Association of Medical Assistants.

After the House reconvened, Doctor Greathouse continued with the assignment of the reports to the various reference committees as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of the Executive Secretary—Reference Committee No. 1

Report of the Council on Scientific Assembly—Reference Committee No. 2

Report of the Council on Medical Education and Hospitals—Reference Committee No. 2

Report of the Council on Legislative Activities—Reference Committee No. 3

Report of the Council on Medical Services—Reference Committee No. 4 with the following exception: page 18, starting at the beginning of the Physical Medicine and Rehabilitation Committee report through the conclusion of the report to page 30, referred to Reference Committee No. 3.

Report of the Council on Communications and Public Service—Reference Committee No. 4.

Report of the Council on Governmental Medical Services—Reference Committee No. 5.

Report of the Judicial Council—Reference Committee No. 6.

Report of the Advisory Committee to Editor—Reference Committee No. 6.

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6.

Report of the Insurance Review Board—Reference Committee No. 6.

Report of the Committee on Arrangements for the Interim Meeting—Reference Committee No. 6.

Report of the McDowell House Board of Managers—Reference Committee No. 7.

Report of the Memorials Commission—Reference Committee No. 7.

Report of the Advisory Committee to Selective Service—Reference Committee No. 5.

Report of the Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 4.

Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund—Reference Committee No. 7.

Report of the KMA Representative to Conference of Presidents and other Officers of State Medical Associations—Reference Committee No. 7.

Report of the KMA Study Committee for Improved Community Health—Reference Committee No. 4.

New Business

The new business was then presented to the House and referred to reference committees as follows by the Speaker:

(A) Resolution of Knox County Medical Society on the subject of Therapeutic Abortion—Reference Committee No. 3.

(B) Resolution of Whitley County Medical Society relating to Therapeutic Abortion—Reference Committee No. 3.

(C) Resolution of Mercer County Medical Society pertaining to Therapeutic Abortion—Reference Committee No. 3.

(D) Resolution of Muhlenberg County Medical Society on the subject of AMA Membership—Reference Committee No. 6.

(E) Resolution of Meade County Medical Society pertaining to Therapeutic Abortion—Reference Committee No. 3.

(F) Resolution of Fayette County on the subject of Medicaid—Reference Committee No. 5.

Following the presentation of this Resolution, Rex E. Hayes, M.D., Chairman of the Board of Trustees, was recognized and read the following motion which was passed by the Board on Sunday, September 24:

"That the Board of Trustees endorse in principle Resolution F (Fayette County) and ask the House of Delegates to adopt a positive stand on usual and customary fees, but with a 90-day limitation for its implementation."

(G) Resolution of Campbell-Kenton County Delegation relative to The Ethics of Individual Responsibility—Reference Committee No. 4.

(H) Resolution of Fayette County Medical Society on the subject of Professionalism in Laboratory Operation—Reference Committee No. 3.

(I) Resolution of Fayette County Medical Society pertaining to Negotiation of Government Contracts—Reference Committee No. 5.

(J) Resolution of Fayette County Medical Society on the subject of Blood Transfusions, Transplants and Related Matters—Reference Committee No. 3.

(K) Resolution of KMA Perinatal Mortality and Morbidity Study Committee on the subject of Home Evaluation Form for Premature and Other High-Risk Infants—Reference Committee No. 2.

(L) Resolution of Jefferson County Medical Society pertaining to Physicians on Hospital Governing Boards—Reference Committee No. 2.

(M) Resolution of Jefferson County Medical Society on the subject of Support of KEMPAC and AMPAC—Reference Committee No. 3.

(N) Resolution of Fayette County Medical Society relative to Fiscal Agent for Title XIX—Reference Committee No. 5.

(O) Resolution of Fayette County Medical Society on the subject of Upgrading Qualifications for Licensure—Reference Committee No. 3.

(P) Resolution of KMA Tuberculosis Committee on the subject of Co-Sponsorship with the Kentucky TB and Respiratory Disease Association of Health Messages Pertaining to Tuberculosis for Outdoor Billboard Advertising with Cost to be Assumed by TB Association—Reference Committee No. 4.

(Q) Resolution of Fayette County Medical Society pertaining to Qualified Osteopaths as Members of State Medical Association—Reference Committee No. 6.

The Vice-Speaker of the House, Carl Cooper, M.D., announced the meeting places for the Nominating Committee for general officers and the five trustee districts. Doctor Cooper pointed out that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning at the Convention Center, and these nominations would again be read at the second meeting of the House on Wednesday. At that time additional nominations, in accord with the Bylaws, may be made from the floor without discussion or comment.

The first session of the House was adjourned at 11:55 a.m.

Second Session

Speaker, Richard F. Greathouse, M. D., called the second session of the House of Delegates to order on September 27 at 7:25 p.m. W. Vinson Pierce, M. D., Covington, gave the invocation. The Chairman of the Credentials Committee, C. J. Brueggemann, M. D., Covington, reported that a quorum was present.

Doctor Greathouse recognized the Chairman of the Board of Trustees, Rex E. Hayes, M. D., who presented the final report of the Board of Trustees as follows:

(This resolution was passed by the Board of Trustees at its September 27 meeting)

"WHEREAS, the 1967 KMA Annual Meeting has made a substantial contribution in the field of continuing medical education and has been well received, and

"WHEREAS, many individuals, organizations and agencies including guests and state essayists, scientific and technical exhibitors, newspapers, radio and television stations, hotels, and the Convention Center, have contributed to its success, and

"WHEREAS, the Trans-Atlantic CPC sponsored by Smith, Kline & French Laboratories has made a valuable contribution to our meeting, now

"THEREFORE BE IT RESOLVED that this House of Delegates goes on record as expressing its deepest appreciation to all individuals and organiza-

tions who have had a part in the development and implementation of the 1967 Annual Meeting." Doctor Hayes moved the adoption of this resolution. The motion was seconded and carried.

In presenting the announcements for the evening, Doctor Asman recognized the following representatives of state medical associations: Richard V. Lynch, M.D., Clarksburg, West Virginia, President of the West Virginia State Medical Association; L. C. Meredith, M. D., Elyria, Ohio, Past President of the Ohio State Medical Association; and Martyn Schattyn, M. D., St. Louis Missouri, Vice President of the Missouri Medical Association.

At this time, Robert E. Pennington, M. D., President, was recognized and stated that KMA President-elect, George F. Brockman, M. D., has twice been to Viet Nam while participating in the AMA Program for Voluntary Physicians for Viet Nam. Doctor Pennington explained that a plaque from the AMA had been received, commending Doctor Brockman for his service. The plaque was then presented to Doctor Brockman.

Following this presentation, the reports of the reference committees were presented.

REFERENCE COMMITTEE NO. 1*

C. Melvin Bernhard, M.D., Chairman

Reports of the Officers and Board of Trustees

Reference Committee No. 1 considered the following reports:

1. Report of the President
2. Report of President, Woman's Auxiliary to KMA
3. Report of President-Elect
4. Report of Speaker of the House
5. Report of Chairman of Board of Trustees
6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the AMA Delegates
10. Report of the Executive Secretary

Report of the President

First, I would like to thank the House of Delegates for the honor of allowing me to serve during the past year as your President. Secondly, I wish to thank the many council and committee members for their time and untiring efforts in behalf of this Association. Many of the meetings were long and more frequent than I had anticipated would be necessary.

With the practice of medicine becoming more complex and the continued intrusion of government into medicine, it has been necessary to increase the activities of our Association in order to keep informed. This has created a hardship for our staff as well as the committee functions.

In order to increase our effectiveness in all fields of medicine and administration, we have had a committee studying the organization and structure of our Association. Recommendations will be made to you for changes. While these may not be ideal in all instances, constructive suggestions are welcomed and are the privilege of this House.

The Bylaws state that each trustee "shall hold at least one district meeting each year in order to afford a forum for the exchange on problems relating to organized medicine and for postgraduate scientific study." Since the latter part of January, I have had the privilege of attending Trustee District meetings in thirteen of our fifteen districts.

At these meetings we have tried to illustrate and inform the membership of the organization, activities, and expenses of our medical association. Also, to point out the necessity of each member being informed and active in the affairs of his local, state, and national medical organizations if he wishes medicine to continue unencumbered by more governmental and bureaucratic regulations.

The response of those attending was gratifying, but the attendance was generally disappointing. It is estimated that only about 10% of the membership was reached by these meetings. The aims, ideals, and activities of headquarters and officials of KMA in behalf of its membership are still too poorly understood by this majority of the membership. Attempts to establish a line of communications between these groups were discouraging. Too many feel that if they pay their dues they have fulfilled their obligation. In reality, this is only the beginning. The more one contributes to our organization the more appreciation and respect he has for it. Unless the membership rededicates itself to the ideals of organized medicine, further governmental inroads into the private sector of medicine are inevitable.

In addition to the District Trustee Meetings, I have attended the Senior Day programs at both our medical schools, the annual meeting of the AMA in Atlantic City, a meeting of the Presidents of the medical societies of the Appalachian states in Washington, the annual meeting of the KAGP, the meeting of the Kentucky Nurses Association, the Congressional Dinner in Washington at which we had our largest attendance to date of such dinners, the program committee meetings of the Interim and the Annual Meetings as well as the numerous Executive Committee and Board of Trustee meetings.

Many meetings I was unable to attend, and I wish to thank at this time the Committee members, the President-Elect, the Vice-Presidents, and the Trustees who have represented this Association on these occasions.

I would be remiss if I did not thank our Headquarters Staff of relieving me of many tasks, for their untiring efforts in making these activities possible, in all instances of keeping me informed, helping obtain necessary information and aids when occasion so demanded, even though it meant working at night and week-ends.

With the practice of medicine becoming administratively more difficult, more work, more diligence, and more meetings are required of your officials. This has thrown such a burden upon the Presidency that many inspiring and capable leaders refuse to accept the office because of the time required and their inability to make such a financial sacrifice and fulfill their obligations to their families and their patients.

Many of the meetings are necessary to carry on the business of the Association. Many are required for public relations, but others are perfunctory and con-

*In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in the Journal, the KMA Board of Trustees passed the following motion "that if no dissenting action on the committee's recommendations is made either by the council under which the committee serves or the KMA Board of Trustees, only the reference committee action on the report be printed in the Journal".

tinued by custom and tradition. I would recommend that the President be relieved of some of these duties.

I would also like to remind the Delegates of their responsibilities under the Bylaws of this Association. The district delegates serve as a nominating committee for the trustee of their district, who is in turn elected by the House. If their trustee does not attend the meetings of the Board, they are not being represented and informed of the activities and policies of the Association. Habitual absenteeism should not be condoned.

Although there is nothing in the Bylaws to the contrary, it has been customary for the Chairman of the Board of Trustees to serve only one term. By the time he becomes familiar with his duties and has confidence in his position, his term expires and a new man goes through the same routine. I see no reason why the Chairman should not serve more than one year any more than the Secretary or Treasurer. I would recommend that consideration be given to lengthening his term.

Robert E. Pennington, M.D., President
Kentucky Medical Association

Recommendations, Reference Committee No. 1

Reference Committee No. 1 discussed in considerable detail the report of the President and wishes to compliment his report very highly. The committee was impressed by the tremendous duties required by the President. The committee recommends that to increase the attendance at the district trustee meetings that these meetings be held along with the county society medical meetings, wherever feasible. It was agreed that the ten percent attendance which was reported by the President is very poor. The committee recommends the appointment of a committee of four or five of the immediate past presidents to make recommendations on methods of decreasing the president's workload. It is hoped by Reference Committee No. 1 that the Vice Presidents could assume more of the perfunctory duties of the President.

The committee felt that the President has served with great dignity and wishes to thank him for his diligent work.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Report Of The President Of The Woman's Auxiliary

In this our 45th year, the Woman's Auxiliary to the Kentucky Medical Association has shown evidence of progress in growth and service.

At the beginning of the auxiliary year, with permission from the KMA Advisory Board, we selected AMA-ERF, Health Careers, Community Service, and Legislation as our main projects to stress on state and local levels.

AMA-ERF donations have increased over last year giving us a total this year of $3,728.02. These funds were raised by many different projects: Christmas card sales, AMA-ERF memorials and jewelry, stationery and the sale of "Dream Pets".

Community service activities and projects are many and varied. We feel our contribution this year to this project has been outstanding. Our members are either working as a group or individually with other organizations interested in health. To start our year we planned our fall conference program to alert the board members of the need for venereal disease education for our youth. After conducting a pilot program in one of our larger counties, all the organized county auxiliaries and Members-at-Large in each county where an auxiliary did not exist, were contacted and our project on V. D. Education explained, and suggestions offered as to how to start such a program in their community. When visiting each county auxiliary, and at each of the 11 District Meetings, the film, "Quarter Million Teen-Agers", was shown, and a speaker (U.S. Public Health Advisor, head of the V. D. control department, Kentucky State Health Department) spoke to the members on V. D. education. A local television station serving central and eastern Kentucky gave a series of 3 half-hour programs with advanced publicity on the problem of teen-age venereal disease. Three county auxiliaries purchased copies of the film, "Quarter Million Teen-Agers", to be used in schools in their communities. Other county groups purchased the student manuel on V. D. to be used in health classes in community schools. With permission from the Kentucky Medical Association, a resolution on V. D. Education, based on one adopted by the Woman's Auxiliary to the American Medical Association at the annual meeting in June, 1967, Atlantic City, will be presented to the Woman's Auxiliary to the Kentucky Medical Association House of Delegates for adoption September 27, 1967. For the 12th year a health citation award will be given to a lay person or organization for an outstanding contribution in the field of health, and also an award will be given to a physician's wife who has made an outstanding contribution to her community.

Interest in health careers has continued to increase. We have thirty very progressive health career clubs organized in high schools throughout the state, and eight health career days were sponsored this year. The state auxiliary currently has four students using its loan fund. There are fifteen students being sponsored by county groups. Approximately 550 medical handbooks, "Horizons Unlimited", were placed in Kentucky schools. Henderson County Auxiliary organized a candy striper program in the community hospital, and trained 60 girls over a 3 year period. Of this number, 12 girls have gone into medical careers.

Although we concentrated on four projects, our members have been active in other phases of auxiliary work: The Bylaws Committee is making changes in the Constitution and Bylaws for the purpose of conforming with changes adopted by the national auxiliary. These changes will be presented for action by this convention, with a proposal that they be reprinted as amended.

Participation in International Health Activities continued this year with sample drugs, rolled bandages, and Johnny coats for World Medical Relief from eighteen counties.

Legislative interest continued with the state president and state legislative chairman serving on the KEMPAC Board. Many auxiliary members are active in KEMPAC within the profession; others take an active part in city, state and national political affairs.

Mental Health activities were reported by twelve county auxiliaries. Two county groups had fund raising benefits totaling $950. The premiere of "Hawaii" in Louisville netted $7,000 for the State Mental Health Association. Two county auxiliaries had mental health programs.

Rural Health: We continued to support Frontier Nursing by sending used clothing, and used toys to be used by little patients in the waiting rooms of the hospital and five outpost clinics. Aprons were made to be worn by nurses at the clinics and during home deliveries. Small cloth bags used to carry supplies were also made. T. V. trading stamps were contributed toward the purchase of a new jeep.

Safety: A program on GEMS (Good Emergency Mothers Services) sponsored by three county auxiliaries is beginning to create interest. Approximately 200 girl and boy babysitters were trained how to identify and handle emergencies more efficiently. Several other county groups are interested in initiating this program next year.

These accomplishments are the efforts of 29 organized auxiliaries with a membership of 1,248. There are 184 Members-at-Large, making a grand total of 1,468 involving 100 counties.

Our WA-SAMA groups, Louisville and Lexington, are doing a fine job.

During the year I visited twenty-six of the organized auxiliaries either individually or at the ten district meetings I attended. On each occasion I talked about auxiliary projects we were stressing, and in several instances installed the new officers. At each meeting I had a planned program on V.D. Education with a qualified speaker from the V.D. Control Department, State Health Department, Frankfort. I attended the annual meeting of the Woman's Auxiliary to the American Medical Association in Atlantic City, June 1967, where I presented the Kentucky presidential report; Fall Conference for state presidents and presidents-elect in Chicago, and an AMA Auxiliary Workshop in Memphis, October 1967.

In March I went as a delegate sent by the Kentucky Medical Association for the tenth annual visit with the Kentucky Congressional delegation in Washington.

I attended a meeting of the Interim Meeting planning committee in November, and the Interim Meeting itself in April held at Ken-Bar Inn, and two KEMPAC Board meetings.

I presided at four Board meetings and the 45th Annual Meeting of the Woman's Auxiliary to the Kentucky Medical Association, September 26-27, 1967.

Articles have been written for four issues of Blue Grass News, the President's page of KMA Journal (January issue), and a report on Kentucky Auxiliary activities for the National Archives and the KMA.

I spoke to the new KMA members, Ken-Bar Inn in April, and again on September 25, 1967 on "The Role of the Doctor's Wife in Organized Medicine."

I accepted the invitation to attend the annual House of Delegates meeting of the Woman's Auxiliary in the following states: Nevada, Ohio, Illinois, and West Virginia.

This past year will long be remembered as one of the most pleasant and challenging years of my life. I sincerely thank the entire membership for their help and cooperation. It is with a deep feeling of gratitude to you for achieving our goals summarized in this report, and for the opportunity of serving as your president.

Mrs. Raymond E. Jones, President
Woman's Auxiliary to the
Kentucky Medical Association

Recommendations, Reference Committee No. 1

The committee reviewed in detail the report of the President of the Woman's Auxiliary. The committee was impressed with the many duties that are now performed by the Auxiliary. The committee wishes to thank the President of the Woman's Auxiliary for a job well done.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Report Of The President-Elect

The only way I can possibly thank you friends who honored me with this assignment is by doing your work to the limit of my talents. This has been my year to learn THE JOB. From what I have seen as I tried to be diligent in my home-work, I can promise you a good year for the Kentucky Medical Association.

Your Board of Trustees has shouldered the responsibilities you gave them, better, I'm told, than ever before. They have acted promptly, vigorously and firmly in crises, to make sure that the practice of medicine is directed along the course that you have found to be right and best. They have not hesitated to speak out firmly against quackery and cultism.

The Hoover Commission, drawing on the wisdom of our most experienced elder statesmen, has spent days of deliberation in planning a new structure for the Kentucky Medical Association—a close-knit, compact, and leaner KMA that will be quicker and more dynamic in meeting the problems that rise in ever-increasing swarms.

Your Technical Advisory Committee—Doctor Garnett Sweeney and his dedicated group—have spent long and incredibly tiresome days in helping the agents of public administration to understand that the basis of all medical care is the physician treating his patient; that the *quality* of medical care is its priceless ingredient; and that unless the physician has the tools and environment to do his best for his patient, welfare medicine must become a sterile numbers game of superficial and symptomatic treatment.

The Council on Legislative Affairs, more experienced than ever, has planned most carefully to make sure that the coming meeting of the Kentucky General Assembly can act wisely and on good information in legislating for the health and welfare of our people. The KMA Washington Legislative Dinner was the best-attended ever and the best-received by our legislators in Washington.

KEMPAC, like the phoenix, soaring steadily higher from the ashes of 1964, was able to have the most outstanding delegation at the AMPAC Washington Workshop, which was itself a new high in physicians' search for effective leadership and expression in public affairs.

In June, I saw the AMA inaugurate a President who has the character to adhere to the old verities of initiative, responsibility, and enterprise, and the courage to speak for them clearly and firmly.

All of these I have seen. Many other good works I have read about, as you have, in these Reports. With all of these good things going for us, KMA would have a good year if Charley McCarthy were President.

George F. Brockman, M.D.
President-Elect of KMA

Recommendations, Reference Committee No. 1

Reference Committee No. 1 reviewed the Report of the President-Elect. The President-Elect, George F. Brockman, M.D., stated before the committee that he observed a tremendous progress in the Association's activities in the last 18 months. He thought the spirits of all the members of the Board of Trustees and the various committees were very high. The committee wishes to extend to Doctor Brockman their very best of luck and Godspeed.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Report Of The Speaker Of The House

You have in your House of Delegates portfolio many reports of committees and officers of your state Association. These men making these reports have labored hard and spent many hours studying the problems of your Association and offering solutions to the various problems. You, as a delegate, will be faced with the solemn responsibility of thoughtfully reviewing these reports well in advance of the meeting time.

We are most grateful to those of you who are willing to give your time and talents in doing the work of your Association. Your faithful attendance and participation in the two major sessions of the House of Delegates are most necessary to the functioning of your Association. The directives and procedures evolved by you and your fellow delegates will serve as a mandate to the officers and trustees of your state society, and it will be their responsibility to implement same.

The two sessions of the House will follow the traditional procedures. At the morning session, we will have the presentation of the reports of the officers, Board of Trustees, councils and committees.

Each report is numbered. As they are received, each will be referred by number to a reference committee.

After all reports have been received, resolutions introducing new business will be in order. These will be alphabetically identified and referred to the appropriate reference committee. At 2:00 P. M. the seven reference committees will meet in their various assigned rooms on the mezzanine floor of this hotel.

Your Speakers urge you to attend, participate in the discussions, and speak your mind freely but concisely.

Perhaps you will be interested in the discussion held by more than one reference committee. To enable you to follow the proceedings more orderly, each reference committee will list the reports assigned to them on a blackboard in the order in which they will be considered. Following completed discussions on each resolution or item, that item will then be marked through on the board. This will enable you to attend only those discussions of interest to you.

Reference committees will stay in session, hearing discussions and testimony until 3:00 P. M. or until all members have been heard. Following this, they will go into an executive session and prepare their reports.

Each delegate will have a complete copy of all reports at the second session of the House on Wednesday evening.

Please be advised that any motions longer than 20-25 words must be reduced to writing, preferably typewritten, with copy forwarded to the Speaker.

In this morning session of the House of Delegates, we will consider that no report or resolution expresses in finality the policy of this Association. We are amenable and will accept at all times information for further study. The action you take as a delegated body on Wednesday night will be the final decision and will remain the policy of the Association for the coming year. The Speaker will follow Roberts Rules of Order in conducting the meeting as provided for in the Constitution and Bylaws.

As Speaker and Vice-Speaker of the House, we are both humble and grateful for the opportunity of serving this body of delegates. We, along with all other officers and the staff, are here to help you make your decisions wisely and well. Please feel free to call on us at any time for additional help that you may need.

Richard F. Greathouse, M. D., Speaker
Carl Cooper, M. D., Vice-Speaker

Recommendations, Reference Committee No. 1

The committee then reviewed the Report of the Speaker of the House of Delegates and wishes to thank Doctor Greathouse for the tremendous job that he has done in organizing all of the committees for this meeting and for the presiding at the two sessions of the House of Delegates. The committee also wishes to express its appreciation for the work done by the Vice-Speaker of the House, Doctor Carl Cooper.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report Of The Chairman, Board Of Trustees

Were it possible for every KMA member to serve on or meet with the Board of Trustees for just one year during his career in medicine—we believe there would be a great revolution in the thinking of our profession. We would all become more aware of—

The problem we have of communicating with each other and the public.

The growing and most significant responsibility we have in seeking to influence, in the public interest, the increasing governmental involvement in medicine.

Paralleling this is the equal responsibility of participating in legislative affairs of our country both in Congress and the Kentucky General Assembly.

The problem of controlling the activities of cultists who would extend their acceptance through legislative procedures rather than through study, training and research.

The obligation of making the Association more effective through adequate financing and improved organizational procedures.

And finally, encouraging each of our KMA members to become more aware of our personal responsibilities as physicians to our patients and ourselves.

During the 1966-67 Association year your Board of Trustees has been facing these problems and seeking to resolve them in the best interest of all concerned. The Board met four times in regular session, once in a special session, for a total of 50 hours. The Executive Committee of the Board met on four occasions, for a total of 17 hours. (This does not include the September 6 meeting.) In addition there was one called meeting and one telephone conference meeting.

Your chairman is aware of the difficulty of making a report of this nature in a manner that will please all—invariably some will say it is "too long," others "that it does not go into enough detail". If additional information is desired, the 233 total pages of the minutes of the Board and Executive Committee are available for any delegate who would like to review them.

Believing that the Speaker of the House most certainly would feel the need to "split" parts of this report among the various Reference Committees of this House, we have followed recognized parliamentary practice and have made three major recommendations on various matters as supplemental reports which can be referred to as a "package" and which are a part of this total report.

We will take this opportunity to express our personal appreciation to our officers and board members for their cooperation, diligence, devotion and performance during this past year.

I would also like to express my sincere personal appreciation to the entire Headquarters staff for their excellent cooperation and assistance they have rendered during this associational year.

First Meeting, September 22, 1966

Henry B. Asman, M. D., KMA Secretary, having been elected to serve as temporary chairman the night before, presided at the opening of this meeting.

George F. Brockman, M. D., was introduced as President-Elect and Richard F. Greathouse, M. D., was the new Speaker of the House. Other officers re-elected to positions formerly held were Doctor Asman as Secretary, Keith P. Smith, M. D. as Treasurer, J. Thomas Giannini, M. D., as delegate to the AMA, Charles G. Bryant, M. D., as alternate delegate to the AMA, Rex E. Hayes, M. D., trustee from the 6th district, and E. C. Seeley, M. D., elected to his first full term as trustee from the 15th district.

Others elected by the House the night before to serve on the Board were Roy H. Moore, M. D., J. Campbell Cantrill, M. D., and James W. Harris, M. D. (now deceased) as the three KMA vice presidents; Carl Cooper, M. D., Vice-Speaker of the House and new trustees as follows: George A. Sehlinger, M. D., 5th District; LeRoy C. Hess, M. D., 8th District; Douglas H. Jenkins, M. D., 11th District; Ballard W. Cassady, M. D., 14th District.

Doctor Hayes was elected chairman of the Board by acclamation and assumed the chair. Joseph R. Miller, M. D., trustee from the first district, was named Vice-Chairman.

The Executive Committee was formed when Doctors Sehlinger and Seeley were elected from the Board to serve with the president, president-elect, chairman, vice chairman, and secretary as provided by the Bylaws. Following comments by the incoming president, the Board proceeded to elect the personnel

for committees and councils for the 1966-67 Associational year.

There was a discussion concerning the need for redefining the aims and purposes of the Association and making a thorough study of its operation. The Board passed a motion authorizing the chairman to appoint an ad hoc committee of at least 12 members to make an indepth study of the organization and the operation of KMA and report no later than the August, 1967 meeting. The new group was to be known as the Commission to Study the Reorganization of KMA.

Second Meeting, December 7-8, 1966

The President's Report highlighted the many activities that the President had carried on in behalf of the Association in the past three months.

The report of the Delegates to the AMA Clinical Meeting in Las Vegas late in November was moderated by our Senior Delegate, J. Thomas Giannini, M. D. Each of the Delegates and the other members of the Board who had worked reference committees at the Las Vegas meeting reported on material covered by reference committees assigned to them.

Henry B. Asman, M. D., secretary, gave the Headquarters Office Report. It was indicated that the staff had worked 22 meetings of committees and councils, 18 meetings of related interest and 7 out-of-state meetings since Annual Session.

The Board of Trustees, having been concerned about fragmentation of health services in Kentucky, had appointed a committee earlier in the year chaired by Gabe A. Payne, Jr., M. D. After two meetings of this committee, Doctor Payne explained that in order to qualify for funds for this study under PL 89-749, that certain conditions would have to be met. He made the following recommendations that were accepted by the Board.

The first, that the Governor of Kentucky in implementing PL 89-749 designate the Health Department as the administering agent. The second recommendation related to the appointment of the State Health Planning Council, which would be composed of 25 members, a majority of which would be in the "Consumer" group.

The third suggestion related to the use of technical advisory committees from the various providers of service to assist the proposed new council.

Doctor Payne indicated that the committee expected to continue working, and his request that the Board ask the Journal to support communications in this field was accepted.

There was discussion as to how Resolution D should be implemented. It was felt by some that this resolution, which calls for a state-wide KMA survey committee for improved community health utilizing study groups from both professional and lay organizations at the committee level, be handed to Doctor Payne's committee for implementation.

Concern was expressed over how much the survey would cost and that no provisions had been made in the resolution for its implementation as provided by the recently enacted Bylaws. After full discussion, it was decided that a committee should be appointed to look into the matter of preparing a cost and feasibility study and to report back to the 1967 House of Delegates.

In compliance with the Kentucky Revised Statutes, the Board of Trustees nominated three Kentucky physicians for each of the two vacancies that resulted from expiration of terms on December 31 on the State Board of Health.

The Board accepted recommendations from the Council on Legislative Activities and agreed to support the Kentucky Farm Bureau and the Louisville Chamber of Commerce on the matter of time change; support the efforts to obtain legislation requiring Immunization Vaccine REH—for measles; resist further attempts in state government to create legislation through a simple appropriation; that all committees and medical groups cooperate in clearing legislative proposals with the KMA Council on Legislative Activities and the authorization of two KMA lobbyists in Frankfort during the Legislature.

A matter relating to the orientation program was disposed of. The proposal for plaques for Board members was indefinitely tabled and the recommendations of the joint KMA-KNA Advisory Committee were approved as amended.

The Board then considered the reaction to the November 11 letter distributed by the State Department of Health relating to procedures for receiving payment under the "medicaid program". Several KMA members testified on this matter and Garnett J. Sweeney, M. D., chairman of the KMA Technical Advisory Committee, discussed the matter in detail. After full discussion, the Board took the following action:

"RESOLVED that Doctor Sweeney's committee be instructed to inform the Department of Health that the physicians of Kentucky insist upon:

(a) One simple form to submit to the Division of Medical Care or Metropolitan (but not both) for payment of their fees for services rendered to government medical care beneficiaries; and

(b) Payment of their usual and customary fees.

RESOLVED further, that the Department be informed that we do not expect action on usual and customary fees until the survey is completed, but that we do expect immediate action on the forms, and that if simplification is not achieved to our satisfaction by January 15, 1967, we will advise our membership that they are not required to accept assignments for their fees from public assistance recipients under Title XIX."

The Board next heard the Chairman of the Committee whose responsibility it is to follow the ODMC and VA Hometown Medical Care programs. Recommendations from L. Douglas Atherton, M. D., the chairman of the Committee, relating to expanding of the Review Committee to include general practitioners and delaying the negotiations of the Hometown service-connected medical care program with the VA until after July 1, at which time the usual and customary fee survey was scheduled to be completed, were accepted.

It was indicated that KEMPAC had 829 members for 1966, which was a new all-time high in Kentucky. Expression of appreciation from the KEMPAC Board to the Board of Trustees was read. The Board of Trustees voted to continue the support of KEMPAC Educational Fund at the same level in 1967 that it had in 1966.

The Legal Counsel discussed the liability the members serving in leadership capacity for the Association might have. The company specializing in this area, which was reported to carry a majority of Kentucky physicians, covers the members for any liability in this area under the clause in its contract which reads "based on professional services rendered or which should have been rendered".

This Board approved this Council's recommendation that KMA support legislation making the Kentucky Department of Health the sole agency for the administering of the medical assistance program of the aged.

The Board approved the recommendation that the "Hoover Commission" study a suggestion which would reportedly prevent overlapping of the duties of certain KMA committees and councils. It was indicated that Resolution H, passed at the 1966 meeting of the House, which called for direct billing under Title XIX of the Social Security Act had been discussed with the appropriate AMA officials and that it was not possible to implement it at this time.

The Board then accepted the recommendation that the Association oppose compensation from governmental sources for services provided by anatomical laboratories that are not under the direct supervision

of licensed physicians. A broad statement of the delineation of the duties of each of the committees under the Council was approved.

The Board approved the recommendation that a careers committee be set up under this Council; that a speakers' bureau which would be publicized to lay organizations be established within the Council, and that the present statewide diabetes detection program be discontinued. Another motion in this area encouraged individual county physicians to carry on the program in cooperation with the State Department of Health.

The Board expressed appreciation to the Central Association of Obstetricians and Gynecologists and to the Southern Surgical Association for contributions to the McDowell House; referred a suggestion that the fiscal year of the Association be changed to end September 30 to the "Hoover Commission"; expressed appreciation to Ellis Fuller, M. D., guest editor of the October issue of The Journal of KMA; heard a report from the AMA Board of Trustees by Robert C. Long, M. D.; made changes in the Maternal Mortality Study Committee as requested and agreed to co-sponsor an infection control course at the University of Louisville.

Third Meeting, April 18-19, 1967

In his report, the President explained that he had attended approximately 13 meetings on behalf of the Association, that the Vice-President had represented him at a number of meetings, and that he had held several conferences with staff. The Secretary gave the Headquarters Office report.

It was reported that physicians who had been occupying offices in a hospital (which had been of serious concern to KMA) had removed their offices and were now practicing away from the hospital premises.

Members of the Board of Directors for the Kentucky Educational Medical Political Action Committee for the new year were nominated and elected by the Board of Trustees. The Board then passed a resolution expressing appreciation to G. L. Simpson, M. D., who had been KMA's representative on and Chairman of the Governor's Advisory Council on Medical Assistance since 1960. Doctor Simpson who had submitted his resignation earlier was praised for his efforts in dealing fairly with the taxpayers of the state, the recipients of the program and the members of his own profession.

The Board then nominated three KMA members (as provided by the statutes) to the Governor from which he was to select one to take Doctor Simpson's place. The Association was later informed that the Governor had appointed E. C. Seeley, M. D., London, one of the nominees, to be the Association's representative on the Council.

The Board approved a recommendation of the Committee on Governmental Medical Services to extend the ODMC and VA Hometown medical contracts pending the completion of the fee study. It also accepted a recommendation to the effect that county medical societies inform the Association of any new OEO programs that were put into effect.

Concerning the remuneration of house physicians, the Board amended a recommendation of the Council on Medical Education and approved the following statement:

"that all funds generated in payment for professional medical services performed by physicians in training be maintained under professional physician control and that the disposition of these funds be left to local policy".

A recommendation of the Council on Medical Services, which read as follows, was accepted by the Board:

"KMA's support of the development of the regional approach be reaffirmed and that physicians be encouraged to participate and be cognizant of regional developments to preclude being displaced by non-professionals that do not have medicine as their primary interest".

A list of 14 members proposed by the Highway Safety Committee to serve on the Kentucky Driver's Limitation Program was read to the Board. The KMA Committee is cooperating with the Department of Public Safety. The Board approved the list.

The Board acted on an Orientation matter, made a committee replacement, and authorized support for Robert C. Long, M. D., who would be making the race for his second full term as a member of the AMA Board of Trustees. (Doctor Long was elected by acclamation at the AMA June meeting.)

At this point Henry B. Asman, M. D., Chairman of the Commission to Study the Reorganization of KMA, was asked to report for the Commission. Doctor Asman explained that the idea for a commission to look into the overall operation of KMA was first proposed by Robert E. Pennington, M. D., when he was President-elect. At the September 22, 1966, meeting of the Board of Trustees, a commission had been named by the Board to make such a study.

Serving on this commission were present officers, past-president, Board members, and AMA delegates who brought a wealth of experience and good judgment to the commission, Doctor Asman said. This Commission had held an afternoon-long meeting with the Executive Vice President of the AMA, its subcommittees had met seven times and the Commission itself later had met twice to finalize its report.

The Commission, it was explained, undertook a detailed study of the Headquarters Office operation, the work of the officers and Board of Trustees, and committees and councils with the view of streamlining the organization's work, deleting obsolete programs, and making the Association more responsive and flexible in carrying on its work.

At this point, Doctor Asman explained that the Commission was making its report to the Board in two parts. Part A would contain those recommendations which if the Board approved could be implemented immediately. The second portion of the report would contain recommendations which if approved by the Board of Trustees would require amendments to the KMA Constitution or Bylaws for implementation.

Part A, Report of Commission to Study KMA's Organization

The following recommendations made by the Reorganization Commission under Part A were approved by the Board of Trustees:

1. That a maintenance fund for new equipment, maintenance of office equipment, building, and grounds in the amount of $2000 be established.

2. It is essential that appropriate staff salaries be paid on performance and in keeping with the market.

3. The Commission's investigation found the Association's pension program was not adequate and that it placed this Association at a disadvantage in competing with industry and other professional associations in obtaining and holding acutely needed skilled personnel. The Commission said it had consulted with the Association's auditor, attorney, and pension consultants, and on the basis of a careful study was recommending a fully qualified plan, which would be acceptable under the proposed pension legislation now pending in Congress which is expected to pass. The new plan would provide pension benefits commensurate with the number of years an employee served with the Association.

Due to the age of the Executive Secretary, a separate deferred income plan for him was recommended. It was pointed out that it was not feasible to include him in the regular pension program but that the proposed deferred income plan would bring his retirement income up to a point consistent with the proposed benefits of the qualified plan mentioned above.

4. On the subject of an additional lobbyist for use in the Kentucky Legislature it was recommended

that the Assistant Executive Secretary be used on an as-needed basis.

5. The Commission noted that in recent times the work of the Board of Trustees had doubled. In order to ease this load and still meet the needs of the day-to-day problems of the Association, it was recommended that the Executive Committee meet between sessions of the Board, monthly if necessary, and discharge more of the Board's responsibilities as outlined in Chapter VI, Section I of the Bylaws.

6. (Members of the Commission did not question the good work of the KMA alternate delegates to the AMA but felt that as an economy move the Association might send one KMA Alternate delegate to each AMA meeting and rotate this among the three alternates. This was the only recommendation under Part A that the Board of Trustees rejected.)

7. On the subject of travel expenses of KMA members, it was recommended

that any member traveling out-of-state at KMA expense be reimbursed for his food, tips, and miscellaneous expenses at a per diem rate of $12. Reimbursement of actual expenses incurred are to be made for transportation (air fare, taxi, etc.) and lodging, with air fares being reimbursed only on the basis of tourist fare rates.

8. On the subject of the McDowell House, the following recommendation was made:

that the McDowell House Board of Managers be encouraged to find a self-sustaining financial program, and further, that this be accomplished within the present annual contribution of KMA.

9. On the subject of Rural Health Conference, the following recommendation was presented:

that the Rural Health Conference be discontinued on an annual basis but that the Community and Rural Health Committee be instructed to work with appropriate organizations in obtaining the desired end results.

10. On the matter of KMA policy for expenditures of committee funds, the recommendation was:

that it be KMA policy that any requests by a committee entailing use of funds or excessive staff time for such purposes must be cleared through the appropriate channels.

NOTE: The recommendations of Part B of the Commission's report as amended and approved by the Board of Trustees are contained in supplemental report A, which is to be regarded as a portion of this report.

The proposed budget for the 1967-68 fiscal year was presented by Joseph R. Miller, M. D., Chairman of the Budget Committee. The recommendations were studied by the Board on an item by item basis and were approved following discussion.

Comments were heard from Robert C. Long, M. D., a KMA member on the Board of Trustees of the AMA, relative to problems at the national level. There was a brief report from the chairman of the KMA Advisory Committee to the Fee Survey. Nominations were submitted to the Governor for him to select a KMA replacement on the Commission for Crippled Children to fill the vacancy created by the death of the late Charles Wood, M. D.

Mr. Davis, on behalf of the Judicial Council, presented two matters for the Board's consideration. One related to a physician who allegedly owned stock in a drug repackaging house, and the other related to a physician whose staff was reported to have engaged in activities which were intended to aid in his deferment from serving in the military.

Russell E. Teague, M. D., State Health Commissioner, was recognized to present a problem before the State Department of Insurance. He reported that Blood Service Insurance Plans, an insurance company providing blood to an insured, was seeking to obtain a license to do business in Kentucky. Following the Commissioner's request, the Board agreed to investigate the matter.

The Board was made aware of contributions to the McDowell House and passed statements of appreciation.

Fourth Meeting, June 11, 1967

The Board of Trustees held a called meeting starting with luncheon, Sunday afternoon, June 11, to hear recommendations from the KMA Technical Advisory Committee to the Governor's Advisory Council on Medical Assistance (also referred to as the KMA Committee on Title XIX).

Garnett J. Sweeney, M. D., Liberty, Chairman of the KMA Technical Advisory Committee, gave the Board a very thorough briefing on the problem of implementing that portion of the Medicaid program relating to laboratory and X-ray fees. After discussion, the Board passed a resolution, the resolves of which were:

"BE IT RESOLVED THAT KMA inform the Governor's Advisory Council and the State Department of Health that henceforth this usual and customary fee survey should be the foundation upon which payments to physicians are made and that we reject the idea of limited and divisionary laboratory and X-ray fees as prepared by the Division of Medical Services, June 8, 1967;

"AND BE IT FURTHER RESOLVED THAT KMA inform the Division of Medical Services that results of usual and customary fee study will be made available to them at the earliest possible date so that they can forthwith begin paying for all physicians' services on a usual and customary basis."

The Board then turned its attention to a discussion of drug formulary, generic prescribing, etc. After full discussion, the delegates to the AMA were authorized to present a resolution at the 1967 AMA Annual Meeting which included the following resolves:

"THEREFORE BE IT RESOLVED THAT the Kentucky Medical Association opposes the establishment of the provision of drugs under Medicare by generic prescription, and

"BE IT FURTHER RESOLVED THAT prescribing by generic drug names not be required under any government regulation or law without first setting up human biologic activity standards with adequate controls to enforce such standards."

The Board also authorized Doctor Sweeney to present this resolution to the Governor's Advisory Council. The Board then heard the full policy of the AMA regarding the circumstances under which physicians should prescribe drugs and adopted the policy wording for KMA *in toto*. The essence of the statement is that a physician should be free to prescribe drugs generically or by brand name for all patients, whether they are paying, Medicare, or indigent patients, the primary consideration being the best interests of the patient.

The Board then faced the problem of exactly how much information developed by the fee survey conducted by Blue Shield should be given to the Division of Medical Care of the State Department of Health. It was recalled that Resolution A passed by the 1966 session of the House provided that the information produced by the survey should be held in confidence and that it would be the responsibility of the Board of Trustees to determine what information should be released. After discussion the following was passed:

"RESOLVED, that the KMA Board of Trustees authorize the Executive Committee of the Board and KPM, Inc., to release to the Kentucky Department of Health the statistical average of fees studied, by procedure, for the purpose of doing a feasibility study to determine the predicted cost of covered services under Title XIX in Kentucky if the benefits are provided and services paid under the usual, customary and reasonable concept."

At this point, the Chairman was asked to read a letter he had received from the Kentucky Academy of General Practice protesting the appointment of John D. Winebrenner, M. D., an area medical director of the United Mine Workers of America in Louisville, as a part-time medical advisor to the Division of Medical Care of the Kentucky State Department of Health for the Title XIX program.

Following discussion the Chairman was authorized to send a concurring letter to the State Board of Health and added the following motion:

"That the Board of Trustees strongly recommend to the State Board of Health that they more closely scrutinize the various appointments of personnel closely related to the practice of medicine and health problems."

Fifth Meeting, August 2-3, 1967

President Pennington told the Board that since the April session he had attended 15 different meetings. He stated that 13 of 15 trustee districts had held meetings during the year, and he had attended each one of them. The Headquarters Office Report was given by the KMA Secretary, and the report of the KMA delegate to the AMA, J. Thomas Giannini, M. D., was presented.

The Board heard background information on the development of the Kentucky Educational Television Authority, which is expected to become operative by September, 1968. When the announcement was made months ago that we would have "ETV" in Kentucky, the Board authorized the appointment of an ad hoc committee to look into the possibility of obtaining this state-wide network for weekly or monthly after hours use in the area of Health Education and Continuing Medical Education. This committee held two meetings and made the following recommendation which was read:

"that a pilot program, funded by the Ohio Valley Regional Medical Program, be established and that the actual mechanics of the program be decided at a later date when more detailed information is available for further study."

After full discussion, when it was pointed out that the Board of Trustees would have to approve the proposed pilot program before it was submitted, the recommendation was adopted.

The Board unanimously adopted a resolution relating to the passing of a former president, G. Y. Graves, M. D., of Bowling Green.

A suggestion by the President-elect that several Trustee District meetings be held prior to the meeting of the 1968 session of the General Assembly in order to acquaint the membership with legislative matters was approved.

The Board voted to hold the 1968 Interim Meeting at the Statler Hilton Motel (formerly the Lamplighter and which has adequate new facilities) in Covington April 17 and 18. (These dates have since been confirmed.)

In considering the recommendations of the Council on Legislative Activities, the Board voted to allow the Council to select Key Men in whatever way that would ensure the system's best performance; to resist adding of additional members to the State Board of Health; and to accept the following:

"that we endorse in principle the Medical Examiner's Act, and that the Legislative Council be empowered to set in motion the necessary mechanics for the drafting and enactment of official legislation in the next legislature."

The KMA Bylaws requiring that the Board of Trustees review the reports of the Councils and standing committees to the House of Delegates at least six weeks before the Annual Meeting were complied with at this session. Committees and council chairmen were invited in to report on their activities, and individual trustees had been assigned several reports to study and comment on these reports following their presentation. This procedure each year takes several hours of the Board's time. Significant actions on these reports as is customary will be attached to each part of the report so that the House of Delegates will have the benefit of the Board's reaction.

A letter was read from the President of the State Board of Health, which had been written to the Chairman of the KMA Board of Trustees in response to the June 11 protest of the Board of Health's employment of John Winebrenner, M. D., as a consultant to the Medical Care Division. The Board found several inaccuracies in the Health Board's letter and authorized the KMA Secretary to write and correct these errors.

Both the Executive Committee and the Board of Trustees gave full consideration to the threat of KMA losing one of its Delegates and Alternate Delegates to the AMA because of the failure of a number of KMA members to pay annual AMA dues in 1967. While it was learned during the discussion that we were "over the hump" this year, it was agreed that efforts should be undertaken to avoid a situation in the future.

Rex E. Hayes, M.D., Chairman
Board of Trustees

Recommendations, Reference Committee No. 1

The committee then considered in detail and liberally discussed the Report of the Chairman of the Board of Trustees. This report was considered by the committee to be a very superior one and it felt that great detail was expressed by its chairman. The Committee then asked Mr. Gaines Davis to give it a more detailed report on PL 89-749. It recommends that a greater percentage of private physicians be included on the State Health Planning Council.

The committee commends the work done by the Board of Trustees.

Appreciation was expressed to the Central Association of Obstetricians and the Southern Surgical Association for contributions to the McDowell House. The committee feels the contribution of the Kentucky Surgical Society is also worthy of note.

Again, the Reference Committee No. 1 wishes to thank the chairman of the Board of Trustees, Doctor Hayes, and all the members of the Board for their hard work so well described in this report.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Report Of The Secretary

As one sits down to write the Secretary's Report for the fourth consecutive year, it becomes more and more difficult to be original.

The work of the Association has followed the same pattern as recent years—the problems have increased in number and in magnitude. The duties of the administrative staff multiply, it seems, each month, and the time, effort, and mileage contributed to KMA by the officers, the trustees, and the committeemen have become truly amazing when compared to what was asked of the men in these positions just a few years ago.

One or two points mentioned in the Secretary's Report a year ago bear repetition. It would be redundant for me to remind you that, as a delegate, you are an integral part of the policy-making body of this organization.

In accepting election to this office you have accepted the responsibility of representing the members in your county, voicing their opinions, participating in the discussions before the reference committees and on the floor, and of making every effort to see that the policy established by this House is in the best interest of all of the members of the Association and of the citizens of Kentucky.

In addition, you have accepted a responsibility to report back to your constituents on the actions that were taken, the policies that were established—and the reasoning behind these actions—so that all of the members of KMA may be well-informed on the functioning of their Association.

These responsibilities cannot be met if a delegate fails in his obligation to attend both sessions of the House. At the final session of the House last year, 70 counties were not represented. Forty counties were not represented at either session.

If a delegate is able to attend these meetings, he should make certain that his alternate will be present, or that the president of his county society has an opportunity to certify another member to serve as delegate. The democracy of the organization is threatened when more than half of the component societies are not represented when policy is established.

The second point to be re-emphasized pertains to communications between the Association and its members. It is most disconcerting to continue to hear members complaining of the Association's actions—or inactions—of the dues, of the officers, of the headquarters staff, etc., especially when such complaints are so often based on obvious misinformation or a complete lack of information.

This is not to question the members' right and privilege to criticize their Association, but constructive criticism should be based on sound and accurate knowledge of the subject in question and can accomplish the most good for all concerned when it is voiced through proper channels: through you, as delegate, through the district trustee, through any officer of the Association, or directly to the Headquarters Office.

KMA devotes a great deal of time, effort, and money to fulfill its responsibility to keep its members informed on the business affairs as well as the organizational and scientific activities of the Association.

This meeting of the House of Delegates, which any member is welcome to attend, the Interim Meeting, Trustee District meetings, the Journal, the Communicator, the Secretary's letter, the Legislative Bulletin, KEMPAC letters and bulletins—all are valuable and authentic sources of information concerning the Association and are available to all members regularly throughout the year.

KMA, I believe, does its part to keep its members knowledgeable—the rest is up to them.

During the past year, your Secretary was privileged to chair the Commission to Study the Reorganization of KMA. Never has a chairman been blessed with a more conscientious, more knowledgeable, or more dedicated committee with which to work. The goal of this commission was "to make certain that the efforts and resources of KMA are aimed in the right direction to obtain the most effective results in the most efficient manner."

The Commission has made its recommendations, some of which have already been implemented by the Board of Trustees; and others, involving amendments to the Constitution and Bylaws, are being presented to you at this meeting for your consideration and action.

The Secretary has also served as a member of the Judicial Council, and as one of KMA's representatives of the Kentucky Allied Medical Council. He attended the Congressional Dinner in Washington and was privileged to represent the President of the Association at several meetings here in Louisville.

Thank you.

Henry B. Asman, M. D.,
KMA Secretary

Recommendations, Reference Committee No. 1

The committee then considered the Report of the Secretary. The committee wishes to thank Doctor Henry B. Asman and Doctor Robert E. Pennington for their work in recommending the ad hoc committee to Study the Reorganization of KMA.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report Of The Editor

Your editors are pleased to report that despite the latest increase in printing and other Journal expenses our revenue from advertising has reduced considerably the deficit we have been experiencing.

The audit for the 1966-67 fiscal year showed a 37% increase in revenue and a 5% increase in expenses, as compared to the 1965-66 fiscal year.

The outlook for the future is not glowing! In 1966, due to the influence of governmental controls and other factors, only 12 new drugs were placed on the market. This reduced potential for new advertising placement. Other controls on how an advertisement must be written and what it must contain tend to discourage the smaller houses from using the printed media.

The above factors have depressed advertising in medical journals at all levels. Due to the vigorous efforts on the part of the State Medical Journal Advertising Bureau, of which we are a member, we have enjoyed better business than the average during the past 12 months.

We were most unfortunate this year to lose our scientific editor, Jack L. Chumley, M. D., Louisville, who died suddenly March 10. Doctor Chumley had served in that capacity since 1952, and his excellent work for the Journal will long be remembered by those of us who were associated with him.

From time to time our supply of scientific papers fluctuates. Right now we are on the low side of the cycle. We would encourage our members to submit carefully written manuscripts. Sharing knowledge with our colleagues for the benefit of all concerned is traditional in medicine.

We hope to revive the Case Discussions Department with the cooperation of our two medical schools. Other new features are under consideration.

Finally, may we encourage every member to read both the editorial and advertising columns as your colleagues are making excellent contributions in the scientific sections which are worthy of your intent.

We owe much to our advertisers who make our Journal financially possible. Moreover, the information in their advertisements makes a vital contribution to the practice of medicine. Please do not overlook an opportunity to express appreciation to these companies and their representatives.

Walter S. Coe, M. D., Editor
Sam A. Overstreet, M. D., Associate Editor
Walter I. Hume, Jr., M. D., Assistant Editor
Joseph P. Sanford, Managing Editor

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Editor. The audit for 1966-67 fiscal year showed a thirty percent increase in revenue and a five percent increase in expenses as compared to the 1965-66 fiscal year. The committee felt that the Editor was to be commended on this financial report. Reference Committee No. 1 wishes to thank the companies and their representatives who have advertised in the Journal and hope that they will continue their support.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Report Of The Treasurer*

Available to all members of the Association is the completed report of the audit for the fiscal year ending June 30, 1967, at the KMA Headquarters Office, 3532 Janet Avenue, Louisville, Kentucky 40205.

Keith P. Smith, M.D.
KMA Treasurer

*(*Note: Please see October Journal of KMA, Organization Section, page 1000 for graph showing distribution of KMA funds.*)

Recommendations, Reference Committee No. 1

The committee then reviewed the Report of the Treasurer. It wishes to thank the Treasurer for his detailed report.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report Of The AMA Delegates

The delegates and alternate delegates to the AMA have attended the Interim Meeting at Las Vegas, Nevada, in November, 1966, and the June meeting in Atlantic City, 1967, as your representatives.

A resolution pertaining to the method of selection of doctors for the draft was presented at your request in 1966 at the November meeting in Las Vegas. This resolution was referred to a committee with other resolutions pertaining to medical manpower for the armed forces as a group, at which time other resolutions were to be considered by the Medical Manpower Committee. Your resolution regarding generic drugs was presented at the June meeting, 1967, and along with other resolutions pertaining to the same subject were consolidated into one resolution which again reiterated the AMA's opinion that a doctor could prescribe drugs of his choice. This maneuver was to circumvent the obvious desire of the H.E.W. regulations regarding Medicare prescription for drugs selection.

Your delegates attended all meetings of both the Interim Meeting and the Annual Meeting of the House of Delegates, the AMA, and were active and participated in the discussions of all things pertaining to medicine as related to the Commonwealth of Kentucky; and expressed opinions, pro and con, of their own belief as best reflecting the opinion of the physicians of Kentucky.

At the June meeting, Kentucky presented for, and had a part in, the re-election of Doctor Robert C. Long as a member of the Board of Trustees of the AMA for another 3 year period.

The most significant action of the House of Delegates at the June meeting in Atlantic City was, we believe, the Inaugural Address of Doctor Milford O. Rouse of Dallas as President-Elect of the AMA. Doctor Rouse made a very forthright and forceful address, in which he outlined events to be expected throughout his coming year as president of the AMA. Doctor Rouse, as you know, is a very dynamic leader and under his stewardship we believe that the AMA positions with the Congress and the bureaucratic organizations in Washington will be well expressed. He will have definite opinions and under his guidance we feel that the AMA's position will be strengthened considerably in regards to avoiding further encroachment on the private practice of medicine by the various organizations who desire this.

Another item which received considerable attention at the June meeting of the AMA was the AMA Group Disability Program which had received considerable notoriety in the past several months. After a day's hearings the Special Reference Committee reported to the House of Delegates, which was subsequently adopted by the House, that attempts should be made to reinstitute the program as had previously been carried on, selecting another carrier for this if it was desirable.

We look forward in the coming year to an AMA, Board of Trustees, and leader who will deal forthrightly with the government, but in which, it is our opinion, all dealings will be by a policy which will reflect the feeling that the private practice of medicine is to continue and not be government dominated, but will be carried on in the true traditions of medicine that the first considerations are the patient's care and the nation's health; and resist the idealogy that nation's health care should be a bargaining power for political aspirations or political gains by any organization.

J. Thomas Giannini, M. D.
Senior Delegate to the AMA

Recommendations, Reference Committee No. 1

The committee then considered the Report of the AMA Delegates. The AMA Delegate had covered the Interim Meeting of the AMA in Las Vegas and the Annual Meeting in Atlantic City with considerable detail. The committee wishes to thank all the AMA delegates and alternate delegates for their excellent work.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Report Of The Executive Secretary

How would you, a busy physician, report to this House of Delegates on your practice for the past 12 months? You've worked 60 to 70 hours each week and enjoyed it all. But what would you say? Well, this is your Executive Secretary's dilemma in trying to report on all that has happened this associational year in the Headquarters Office.

This year, we hope to make our report shorter, yet endeavor to give you a quick picture of the highlights of our operation.

That 1967 House of Delegates envelope you are carrying might be described as a resume of our work. In the reports relating to the committees and councils, our staff sat in 143 meetings for a total of 375 hours—at 40 hours a week that's about nine weeks. You can be sure much work went on before and more work after those meetings carrying out your directives.

Your KMA Board of Trustees held four meetings for a total of 50 hours and the Executive Committee met four times in regular sessions, had one special meeting and one telephone conference for a total of 17 hours. The work of the Commission to Study the Reorganization of KMA and implementation of Title XVIII and XIX (Medicare) has added greatly to the Board's responsibility as well as your executive staff's duties.

Routine responsibilities include coordinating and processing the material necessary to getting the Journal out each month. (We appreciate the opportunity to meet with the editors for an hour every 2 weeks.) Other publications include the Communicator, Legislative News Bulletins, and special mailings which we of the staff distribute under appropriate supervision.

A rapidly growing activity of our office might be labeled "special services". These unpredictable duties may take minutes, hours and sometimes a day or more to carry out and are generally emergencies. They include such matters as Selective Service, need for physicians' services, acute legislative problems, cult matters, Medicare or Medicaid frustrations, irate patients and membership misunderstandings. We could go on and on.

This kind of activity does not lend itself to formal reporting or adequate planning of your work load. It is an ever-expanding service which the staff is glad to perform. Unfortunately time runs out too often and we do not accomplish as much as we would like.

Other evidences of staff activity are the tremendous volume of work in putting this meeting together, the Interim Meeting, the two Orientation Courses each year, Senior Day and occasional special meetings we work on for KMA in cooperation with allied groups.

We are most grateful to the members of the Board for the guidance and leadership which have enabled us to handle our operational problems more effectively. In addition, its sympathetic concern for the welfare of the staff members is deeply appreciated.

Speaking individually as Executive Secretary, we want to express our never ending gratitude to the

members of our staff for their splendid performance during this past year in working for your best interests.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The committee then reviewed the Report of the Executive Secretary. The Executive Secretary has done, as usual, a masterful job. It seems to those who have been on this reference committee before that the Executive Secretary does an increasing amount of work each year and it wishes to express its compliments and sincere appreciation for a job well done.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1 as a whole.

(Motion was seconded and carried.)

I wish to thank the members of the committee for their hard work and their patience.

REFERENCE COMMITTEE NO. 1

C. Melvin Bernhard, M.D., Louisville, Chairman
John F. Berry, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hyden
Thomas L. Heavern, M.D., Highland Heights
R. J. Phillips, M.D., Owensboro

REFERENCE COMMITTEE NO. 2

Eugene H. Conner, M.D., Chairman

(Reports on Scientific Assembly and Medical Education)

Reference Committee No. 2 considered the following reports:

11. Report of the Council on Scientific Assembly
12. Report of the Council on Medical Education and Hospitals

Resolution K—Home Evaluation Form for Premature and Other High-Risk Infants

Resolution L—Physicians on Hospital Governing Boards

Report Of The Council On Scientific Assembly

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Scientific Assembly is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*
2. *Reports of the committees of this council.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Scientific Assembly met last fall, early in the associational year, to coordinate the plans for the activities associated with the 1967 KMA Annual Meeting. Having held three previous annual sessions in the Louisville Convention Center, the Council members had an opportunity to review the past programs and related activities as presented in this facility and the Kentucky Hotel. Your council members were well satisfied with the facilities and layout of the meeting, and no major changes were made.

It is a continuing pleasure for us to report a record equalling sixteen specialty groups are again meeting in connection with this year's Annual Session. Approval by the specialty groups of the facilities offered by the Convention Center for their Tuesday and Thursday afternoon meetings was noted with gratitude. The facilities permit all scientific meetings to be held under one roof.

The scientific program will be enhanced this year by the Smith, Kline, & French sponsored "Transatlantic CPC" with England and a new feature entitled the "What's New Symposium." Our sincere appreciation is expressed to our friends at Smith, Kline, & French Laboratories, who again are assisting in making our program a successful one.

We also wish to express our appreciation again to the Southern Bell Telephone and Telegraph Company for sponsoring the Message Center in our Technical Exhibit Hall. This continues to be a growing and most valuable service to our association and our members.

We could not complete our report without extending a hard-earned, laudable note to the members of the Scientific Program Committee, who have assembled a most interesting and profitable program; and the other members of this Council whose accumulative efforts have made this meeting possible. The members of all the committees serving under this Council have contributed many hours of work toward the success of the 1967 KMA Annual Meeting.

The following reports of the committees serving under the Council are herewith submitted:

Scientific Program Committee

Roderick MacDonald, Jr., M.D., Louisville, Chairman

Your scientific program committee began working at the close of the 1966 Annual Meeting to plan your annual session for this year. At our initial meeting in early November, the ground work was laid and general plans for the scientific session were finalized.

The establishment of themes for each one-half day session, an innovation of last year's meeting, proved so successful that we have continued that policy for this year. These themes aid in the continuity of the scientific program, and we hope prove to be profitable to the membership.

In December, a meeting was held with the presidents of the sixteen specialty groups cooperating in the presentation of your annual meeting to outline the plans for the 1967 session and the role of the specialty groups. Our appreciation is extended to these organizations and their officers for the complete cooperation received which is essential in presenting a quality program.

The one hour "Transatlantic CPC" between the Louisville Convention Center and England will be an interesting and educational highlight of our program this year. We especially express our gratitude to the sponsors of the "Transatlantic CPC," Smith, Kline & French Laboratories, Inc., to the moderators and panel members, all of whom have expended considerable time in planning this particular session for you.

Your chairman and KMA staff members have participated in numerous meetings, not previously mentioned, countless telephone conversations, and conducted an incalculable amount of correspondence in putting this program together.

It is the desire of your committee members to present an appealing and educational program that pro-

duces maximum benefit to the membership of KMA. We strive to select the most popular aspects of previous sessions and blend these with new concepts in attempting to reach this desired goal.

Scientific Exhibits Committee

Thomas R. Marshall, M.D., Louisville, Chairman

The Scientific Exhibits Committee will meet on July 13; and as is customary, we are submitting our report in advance of that date to enable its inclusion in the report of the Council on Scientific Assembly for early distribution to the Board of Trustees. Your committee's policy of accepting only those exhibits of truly scientific nature is part of our program to continue to upgrade the quality of exhibits presented. We expect to have about twenty scientific exhibits for this year's meeting, and they will be in place by 8:00 a.m., Tuesday, September 26, and are not to be removed until 3:30 p.m. on Thursday, September 28.

A special committee will judge these exhibits on Tuesday morning, September 26, and select those which are considered to be the most outstanding presentations. Certificates will be awarded to all scientific exhibitors, and special awards will be presented to the winners selected.

We would like to take this opportunity to express our gratitude for the many KMA members who have presented exhibits to this and past years at our Annual Session. We appreciate their interest in this important phase of continuing medical education and urge others to consider presenting such exhibits in the future.

Members of this committee wish to strongly urge all of our members attending the 1967 KMA Annual Meeting to visit these outstanding exhibits which are located in the Convention Center in the area between the Technical Exhibit Hall and the Scientific Sessions.

Technical Exhibits Committee

Willett H. Rush, M.D., Frankfort, Chairman

Your committee, which is charged with the responsibility of renting space in the Technical Exhibit Hall to help finance the expense of the Annual Meeting, wishes to make the following report.

Since the rental on the Convention Center was increased $500 this year, and since a second increase in one-half that amount is scheduled for next year, your committee has decided that an increase of approximately 5% across-the-board in rental of booth space to our exhibitors was indicated. This was approved by the Executive Committee.

We are pleased to report that, in spite of the profit squeeze, the competition caused by growing numbers of medical meetings, and other factors influencing the situation, we were able to sell all 75 exhibits which equals the all-time high we established several years ago and which has been maintained. Although we are a small state, we have one of the larger exhibit halls.

Nowhere can a member of the Association go and obtain more authentic knowledge with such ease in such a short time and at no expense which is so necessary in carrying on the day-to-day practice of medicine as is possible in our Exhibit Hall.

Your committee would strongly urge all delegates and members of the Association to visit each booth and express appreciation for the support of our exhibitors. Certainly, the Committee on Technical Exhibits is very appreciative of the patronage of our family of exhibitors. We also want to thank our members for supporting our exhibitors.

Golf Committee

Donald L. Ware, M.D., Louisville, Chairman

The Golf Committee did not have an official meeting this year as our tournament was scheduled and is planned to be implemented under the policies established for the tournament some three years ago.

A change in the committee was made late during the Associational year. Berel L. Abrams, M.D., Louisville, was the original chairman of the committee this year as our tournament was scheduled to be played at Standard Country Club. When it became apparent the tournament would have to be held elsewhere, it was rescheduled for Hurstbourne Country Club requiring a necessity in appointing a new chairman.

The Golf Tournament will again be held on one day only, Monday, September 25, affording the golfers a maximum fellowship and an equal opportunity in the tournament itself. As in the past, trophies and other prizes will be presented following completion of the day's activities.

We will again use direct mailings, articles in The Journal and the KMA Communicator to promote our tournament. All applications for those desiring to play must be submitted to the KMA Headquarters Office by September 1, 1967, along with the member's golf dues for this year so that appropriate plans can be finalized for the day's activities.

It is the committee's desire to present a tournament that is enjoyable to all participants, and we hope this will be accomplished during this year's tournament.

COUNCIL ON SCIENTIFIC ASSEMBLY
George F. Brockman, M.D., Greenville
Peter P. Bosomworth, M.D., Lexington
Richard F. Grise, M.D., Bowling Green
Roderick Macdonald, Jr., M.D., Louisville
Thomas R. Marshall, M.D., Louisville
Willett H. Rush, M.D., Frankfort
Robert E. Pennington, M.D., London, Chairman

Recommendations, Reference Committee No. 2

The Report of the Council on Scientific Assembly was reviewed by Reference Committee No. 2. The committee wishes to recognize the outstanding work that has been accomplished by this council.

Reference Committee No. 2 wishes to recognize the outstanding scientific program assembled by the Scientific Program Committee.

The committee wishes to recognize the outstanding quality of the scientific exhibits presented.

Reference Committee No. 2 wishes to extend compliments to the Technical Exhibits Committee for their outstanding work.

Reference Committee No. 2 recommends that the Golf Tournament be open for four days of the meeting to enable more physicians to participate in this function, provided that such arrangements can be made with a country club. The reference committee recognizes the outstanding work done by this committee during this Associational year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded and carried.)

Report Of The Council On Medical Education And Hospitals

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Medical Education and Hospitals have met two times during the Associational Year—December 15, 1966, and May 25, 1967.

At its first meeting, the duties of the Council in the new KMA organizational structure were reviewed, and it was pointed out that the Ad Hoc Committee to study KMA operations and organizational structure was at work during this year, and might further modify the future structure of this Council.

The committees serving under this Council this year have been the Advisory Committee to the Medical Schools, the Hospital Committee, the General Practice Committee, the Maternal Mortality Study Committee, and the Perinatal Mortality and Morbidity Study Committee. All except the latter two committees have representatives at the Council level.

The Council has noted and followed with interest the progress of the Ohio Valley Regional Medical Program, and has received progress reports from Doctor Donn Smith, a member of the Executive Committee of that organization, at both meetings.

At the first meeting, the following referrals from the KMA Executive Committee were considered:

A. Training for audiometric technicians and supervision of audiometric testing by physicians was considered and referred to the Advisory Committee on Medical Schools.

B. General Practitioners on Medical School faculties—this issue was discussed by the two medical school representatives, and it was agreed that the two schools in the Commonwealth are cognizant of the problem and efforts are being made to train general practitioners, within practical limits at this time.

C. Two AMA resolutions dealing with relationship between medicine and osteopathy were considered at this first meeting and referred to the Legislative Council.

D. Note was taken at this meeting of the change in the AMA-ERF loan policy, in which the interest rate was increased, and the amount to be borrowed limited somewhat.

E. A preliminary discussion of the relationship between the KMA and the educational TV network in Kentucky was carried out at this time.

At the second meeting of the Council on May 25, 1967, the reports of the meetings of the various committees were considered.

A. The Advisory Committee to the Medical Schools recommended, and the Board of Trustees had approved, the second conference on medical education to be held early in 1968. A committee chaired by Doctor Andrew Moore was set up to arrange this meeting and draw up the program.

B. Nominees were selected from each of the Medical Schools in the Commonwealth for the 1967 KMA faculty scientific achievement award.

C. A committee was set up, after discussion, to determine methods for evaluation of coronary care units throughout the Commonwealth.

D. As a final item of discussion, it was noted that under the proposed change in organizational status, this Council will cease to exist; and it was felt by all members that this Council had represented a unique body for interchange of ideas, especially between those in academic medicine and those in the "field", and it was recommended that the two Deans of the Medical Schools be appointed on any future "Committee on Medical Education and Hospitals" and that some physician member of the State Department of Health also be assigned to this committee. The reports of the committees covering their activities and specific recommendations follow.

Advisory Committee To The Medical Schools

Andrew M. Moore, M.D., Lexington, Chairman

The Advisory Committee to the Medical Schools met on January 12 and after discussion of the responsibilities of the committee, we reviewed the final reports last year when there was a separate advisory committee for each of our two medical schools.

One matter receiving our attention was originated by the Industrial Health Committee in 1966 and pertained to the training and supervision of audiometric technicians. Earlier this year we recommended to the Board of Trustees that training of audiometric technicians should be encouraged under properly qualified instructors at medical centers utilizing university facilities available, and that emphasis be given in such programs as to the limitations of these technicians. Upon our recommendation, the matter of supervision and training of audiometric technicians was referred to the Kentucky EEN&T Society for comment and their recommendation.

Since the use of qualified general practitioners on medical school faculties has been encouraged in the past, it seemed appropriate that our committee discuss this subject in conjunction with the AMA Report on "The Graduate Education of Physicians" and the "Ad Hoc Committee Report on Medical Education for Family Practice." Without making definitive recommendations, the committee members did conclude that medical education at both the undergraduate and postgraduate levels points toward further development and establishment of training programs to overcome any fragmentation of medical education as changing concepts bring reappraisals. There is evidence to indicate that established training curricula at both Kentucky medical schools are under the school staff and faculty surveillance for practical opportunities to increase the training of primary or family physicians. As the schools' current programs develop, it is anticipated that new positions will be created for this type of physician on the full time faculties of the schools.

Also brought to this committee's attention for consideration by its membership during the Associational Year were the handling of funds received in payment for professional medical services by interns, residents, and other house physicians, as well as various reports and resolutions approved by the AMA House of Delegates dealing with medical education.

The committee members see a pressing need for endowment scholarship funds at Kentucky's medical schools. These scholarships should be such that the selected students have no obligation to repay the schools, or else be faced with the possibility of losing top medical students to out-of-state schools which offer such non-obligatory scholarships.

The success of our first Conference on Medical Education in January, 1966 resulted in the recommending that another such conference be held in 1968, and this has been approved.

We were also pleased to have as a guest at our meeting, William H. McBeath, M. D., the Regional Planning Director for Heart, Cancer and Stroke, who presented a comprehensive informational report on the implementation of PL 89-239, the Heart, Cancer and Stroke Law.

Your Chairman is most grateful for all of those who have demonstrated their interest and contributed to the activities of this committee during the past year with a special expression of appreciation to the deans of our medical schools and the members of the Advisory Committee.

General Practice Committee

Charles B. Spalding, M. D., Bardstown, Chairman

The General Practice Committee held its meeting on May 11 during the Annual Assembly of the Kentucky Academy of General Practice.

This committee has been concerned for a number of years with the decline in the number of physicians entering general practice and has attempted in various ways to encourage methods of education and training that will attract young physicians to this field of medicine.

Student exposure to the general practitioner appears to be very beneficial and the University of Kentucky program offering students the opportunity to train with a general practitioner during the summer months is considered by our committee to be a most worthwhile project. We also feel that more vigorous programs should be adopted to stimulate students to become general or family practitioners.

The report of the AMA Ad Hoc Committee on Education for Family Practice and the Millis Report were distributed to our committee members in advance of our meeting and discussed at the meeting. Your General Practice Committee recommends to the House of Delegates that these two reports be recommended to our two medical schools for study and implementation of a Family or General Practice Department, that the schools take a lead in initiating a program on education for family practice, and that the schools maintain the present training system of rotating internships at least until the full Department of Family Practice has been implemented and is operational.

It should be reemphasized that Family Practice Departments (as suggested in the reports) have an administrative unit with a full time staff equal to the present department. The primary purpose of this department is to coordinate medical training and produce family practitioners as stated in the reports. These general practice units should not be under the other services such as Medicine, Public Health, or Community Medicine but should be coordinated under and with the Department of Family Practice.

This committee, as a result of our discussion of Governmental Medical Programs (especially Titles XVIII and XIX of PL 89-97) recommends to KMA that general practice not be put on a separate scale of payment and that all government programs be evaluated as to their effect on general practice. Specifically, there should be no differential established with particular reference being made to dual fees. We appreciate the support that KMA has given to the profession for the principle of the usual and customary fee concept, and we invite and encourage the continued support of this principle to the end where it replaces the split or dual fee system that discriminates against the physician in general practice.

The Heart, Cancer, and Stroke Program was discussed, and we feel that the available grants should be directed in education, training, and research.

Our committee members reviewed and support AMA Resolution 59 (Clinical Meeting, 1966) entitled "The Private Physician's Office as a Center for Comprehensive Medical Care", and we further suggest that all programs relating to patterns of medical care emphasize the role of the private physician's office as a center for comprehensive medical care.

KMA's efforts in planning to utilize educational television as a means for the continuing education of physicians was noted with an expression that we feel it not only an excellent media for assisting the general practitioner but also an aid to encourage general practice. ETV can play a significant role in our public relations program and could promote better and more well understood medical care in the state.

We recommend that a representative of each of our medical schools be invited to this committee's meetings and that the deans of the schools be informed that this committee is available to them and would be happy to assist them on any problems they might have within the realm of our responsibility.

It is suggested that the chairman of this committee be rotated and new chairmen selected from those who have previously served on the committee.

KMA Hospital Committee

James B. Holloway, M. D., Lexington, Chairman

Your Hospital Committee has had another busy year with considerable activity directed toward our "Dry Run Accreditation Team" visits to hospitals desiring to apply for accreditation to the Joint Commission on Accreditation of Hospitals. This "Dry Run" program is a joint effort of the KMA Hospital Committee, the Kentucky Hospital Association, and the Kentucky Association of Medical Record Librarians. Other matters of interest to our committee were discussed and acted upon at our two meetings which were held on December 22, 1966 and May 11, 1967.

This committee has been continously involved with Resolution A passed by the 1965 House of Delegates entitled "Administrative Relationship Between Hospitals and Private Practitioners of Medicine Within Hospitals." Our latest effort in this regard is a survey of Kentucky's radiologists and pathologists scheduled for late May of this year relating to billing procedures. It is expected that the results of this survey will be available prior to the Annual Meeting.

Area-wide hospital planning has been considered by this committee numerous times and has been tabled pending the development of further interest and until clearer concepts become apparent.

At the request of the Board of Trustees, your Hospital Committee studied the matter of remuneration of interns, residents, and house officers. A recommendation for KMA policy on this subject was presented to the Board which will be reported to you in the report of the Board of Trustees.

The fact that a Blood Service Company wanted to initiate an insurance plan in Kentucky was referred to us for consideration. It is our understanding that this company would guarantee an insured blood whenever needed for a policy costing $7.50 per year. We were told that this company is not made up of physicians, has no medical direction, and is not responsible to any medical group. We recommended to the Board of Trustees for consideration at their August meeting that since the organization has no physician in charge that they not be allowed to operate in Kentucky because the furnishing of blood is a medical service. It should be emphasized that blood transfusions result in a respectable number of deaths in the country each year. We cannot believe that blood obtained without medical supervision and not under the care of a knowledgeable physician be particularly true if it were sent to a hospital without a competent blood bank already in function.

This year we would like to take the privilege to report in more depth to you on our "Dry Run" activities and hope you find this to be informative as one of the activities of one of your Association's committees.

Our "Dry Run" teams were organized in 1962 with three four-man teams, one for the Western, Central, and Eastern regions of Kentucky. Each team consists of two physicians, one hospital administrator, and one medical record librarian. Each team also has alternate members to keep from overloading any one individual or to fill in when regular members are unable to make a visit.

The purpose of the "Dry Run" Accreditation Program is to help raise the level of patient care in hospitals within the state up to a minimal standard as determined by the Joint Commission on Accreditation of Hospitals. Since the Dry Run Accreditation Program is expected to play a major role in upgrading the level of patient care in hospitals throughout

the state, the members who receive appointment to these Accreditation Teams assume a highly significant responsibility. In the performance of their duties, the teams use the same guidelines and "inspection" forms as the Joint Commission.

It is to be remembered that a visit by a "Dry Run" team in no way insures the host hospital that it will receive accreditation by the Joint Commission. The "Dry Run" team serves merely in a consulting and advisory capacity to the hospital visited. The utilization of this service by hospitals will, to a great extent, depend upon the willingness of the hospitals already visited to publicize the value of this program as they have experienced it. Certainly a great amount of appreciation is due the members of these teams for the service they perform and the time they sacrifice.

Initially, the desire for assistance from the "Dry Run" Accreditation Program must originate from the individual hospital. No effort will be made by the sponsoring Association to schedule "Dry Run" team visits with hospitals without first receiving a written request from the administrator of the hospital, which is also signed by the chief of its medical staff and chairman of its Board of Trustees.

We would like to impress upon you that the teams approach each visit with an objective viewpoint, and all recommendations made are done so with the best interest of the community in mind. To date, we have conducted twenty "Dry Run" visits, and this activity is increasing monthly, especially since passage of the Medicare Law. Only three visits were made during the first two years, four were conducted during 1964, five during 1965, and seven more during the last year or so.

During this past Associational Year, visits were made to Mount Sterling and Irvine. In addition, other requests are expected to be received during the next few months. The visits are day-long affairs during which we meet with all parties having hospital responsibility. We review the over-all operation of the hospital, records, Bylaws, ancillary services, plant layout, cleanliness, etc. At the end of the day, we meet again with all parties concerned and present to them the recommendations we feel to be in the best interest of the community.

No written record is made by the team, and none is kept. Results are given in detail at a final conference with the Hospital Administration, Medical Staff, and Board of Directors. We emphasize the importance of having an adequate representation of each group at the final meeting. The report is critical and frank, sometimes brutally so, but we feel that it is better to be critical now than have the hospital fail examination by an outsider.

Your Hospital Committee has also been called to trouble spots within the last year to discuss frankly with Hospital Administration, Medical Staff, and Board of Directors various problems that have come up in the community that are interfering with the efficient running of the hospital and its function as an aid to the community. In some instances these abbreviated "Dry Run" trips have been of considerable aid to the community, and in others the results are not yet at fruition. The sponsoring organizations feel that the "Dry Run" activity is a valuable service performed, and it is our desire to continue it.

Other matters receiving our attention this past year have been those relating to hospitals under discussion or receiving action by the AMA House of Delegates. Your committee strives to keep abreast of all important developments within the realm of our responsibility both at the national and state level to be of maximum service to you.

We are most appreciative for the continued cooperation of the Kentucky Hospital Association during this past year, both for the "Dry Run" program and other activities of this committee.

Maternal Mortality Study Committee

Douglas M. Haynes, M. D., Louisville, Chairman

The Maternal Mortality Study Committee met twice during the year and a third meeting has been planned for shortly after the deadline for submission of this report. On September 30, 1966, during the Annual Meeting of KMA in Louisville, ten protocols were reviewed by the Committee. At a meeting held at KMA Headquarters in Louisville on February 2, 1967, the Committee discussed nine cases. An open meeting of the Committee will be held in Lexington on May 20, 1967, during the Annual Meeting of the Kentucky Obstetrical and Gynecological Society, when it is planned to review the protocols of ten cases.

The policy of publishing selected protocol abstracts in the KMA Journal with an abstract of the Committee's commentary on each case has been continued this year. The Committee feels that this is a useful way of bringing its activities to the attention of the profession in Kentucky, and plans to continue to provide these reports.

Perinatal Mortality and Morbidity Study Committee

Guy C. Cunningham, M. D., Ashland, Chairman

The Perinatal Mortality and Morbidity Study Committee met on Thursday, January 19, and had as guests members of the Committee on Fetus of the Newborn of the Kentucky Academy of Pediatrics.

One of our major discussion items was the unevenness of the U. S. perinatal mortality rate among population groups. Of even greater concern than the slowing down in our progress in the reducing of infant mortality is the unevenness of progress between comparable statistics for the white and non-white population groups, and the differentials in pregnancy outcome between private quartered and ward patients.

The prematurity rate has steadily risen to the current level of 10 percent of live births. For the white population, it is 7.5 percent and for the non-white, it is 16 percent.

The infant mortality rate per thousand births for the white population is 22.3 and for the non-white it is 41.3. These statistics point to the need for expanding the philosophy and practice of "total maternity care."

Doctor Stewart Clifford of Harvard Medical School believes, as do many others, that efforts to significantly reduce infant mortality have failed because they have been unable to reach the 1.3 percent of the births that contribute 1/3 of the infant mortality and 50 percent of the neonatal mortality; namely, the infants weighing 1500 grams or less at birth. Thus, the need for a preconceptional and interconceptional care program is indicated. This would be a comprehensive program designed to benefit these low birth weight infants that would have its beginning prior to conception and continue through and between pregnancies.

One professor of bio-statistics (J. Yershalmy, Ph. D., of the University of California) disagrees with the current method of identifying the high-risk case after she becomes pregnant. He maintains that the high-risk case must be identified before pregnancy and thus allow for preventive as well as for curative services. Obviously, this would be very important among the non-white and indigent segments of the population. Furthermore, there is increasing evidence of which we are all aware that the greatest single cause of perinatal loss is low socio-economic status, where the perinatal mortality rate is approximately twice as high as the rates of the more favorable socio-economic groups.

Ralph Reis, M. D., of Northwestern University School of Medicine, suggested at the AMA's National Conference on Infant Mortality, that one of the more important contributing factors in the infant

mortality rate, i. e., prematurity, may be due to increasing ability to prolong abnormal pregnancies through the period of immaturity into the period of prematurity thus increasing the percent of prematurity. The question then raised is whether the increase in prematurity might not in many cases reflect better rather than poorer obstetrical care.

At the same meeting, Arthur J. Lesser, M. D., Deputy Chief of the Children's Bureau, U. S. Department of Health, Education and Welfare, noted the apparent increase in the proportion of infants born weighing 2,500 grams or less since 1960—7.7 percent to 8.2 percent in 1964. He warned of a possible increase. He projected by 1970 that we could expect about a 10 percent increase in premature births over 1964. This projection according to Doctor Lesser, reflects the increasing proportion of non-white infants being born as well as the continuing rise in prematurity among this group from 10.4 in 1950 to 13.9 percent in 1964.

The four main complications of the neonatal period, which account for close to 90 percent of all infant deaths in this period are:

1. Prematurity.
2. Congenital malformations.
3. Anoxia.
4. Birth trauma.

Your chairman believes the general recommendations from the AMA Committee on Maternal and Child Care which we discussed last year are the best guidelines for this committee in our state. They are as follows.

FOR PRIMARY PREVENTION:

1. Improve methods of early identification of "high-risk" mothers.
2. Identify all "high-risk" newborns by means of Apgar ratings and other techniques.
3. Improve infant resuscitation techniques.
4. Reduce infections in newborns by known methods.
5. Extend the present "know-how" on the care of prematures.
6. Evaluate present prenatal-care facilities and practices at the local level and institute remedial measures wherever necessary.
7. Promote participation in prenatal and expectant-parent classes and prenatal clinics.
8. Use caution in prescribing diagnostic x-ray procedures and drugs for potential mothers.
9. Discuss contraception and family planning practices routinely with patients in mutually acceptable terms.
10. Extend postgraduate education programs in obstetrics and pediatrics.

FOR SECONDARY PREVENTION:

1. Promote the organization of perinatal mortality study committees in all hospitals and communities.
2. Calculate annual premature, infant, fetal, perinatal, neonatal, and postnatal rates at all levels of investigations.
3. Compare the rates with other local, state, and hospital committees.
4. Investigate all infant deaths, at a local level to determine preventability factors.
5. Implement any needed corrective measures after the analysis and evaluation are accomplished.
6. Match and evaluate the neonatal-death and birth-certificate data.
7. Analyze all fetal-death certificates.
8. Evaluate the local hospital and prenatal-care services according to the standards recommended by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.
9. Encourage organized research projects and contribute self-initiated research to the literature.

Another matter discussed by the committee was the need for a homogeneous evaluation form for hospitals which would be used as a follow-up guide for premature and high-risk infants upon their discharge from the hospital, with the follow-up being made by a public health nurse.

Earlier this year we recommended to the Board of Trustees that such a form be developed for use in hospitals throughout the state, and we requested the Fetus and Newborn Committee of the Academy of Pediatrics to take on the project of developing the form and keeping us informed of their progress.

The committee members also discussed whether or not Kentucky should have nursery standards in Kentucky Hospital Regulations. It was pointed out that these should come from medical authorities and not from the Commission on Joint Accrediation for Hospitals in Chicago.

One committee member noted that she had been curious on how many states had nursery standards. She heard from 40 of the states queried; out of this, 32 had nursery standards.

It was our opinion that a survey of the hospitals in the state should be made to see whether these standards are needed and how they should be set up. It was pointed out that a survey has been made in the past. We are checking to see when the survey was made and what the results of the survey were. The results of the survey would be the first step in making a recommendation regarding these standards.

It was the consensus of the committee that licensing now does not require standards regarding nursery and maternity care. This committee is hopeful that licensing standards could suggest that, when possible, the hospital follow the nursery standard set up by the Academy of Pediatrics.

We considered the need for a team approach to perinatal mortality and morbidity and agreed to meet jointly with the Maternal Mortality Study Committee when there is sufficient material.

A couple of years ago, this committee recommended the establishment of premature nursery care training centers. As of this writing, the first three of these have been held at the University of Kentucky and were considered quite successful.

The committee discussed training nurses and assistants and the use of LPN's in taking care of newborns noting that they all can be valuable assistants. Some hospitals are training people who have not graduated from high school to do certain things in the nursery, thus leaving the R. N. free to take care of the high-risk babies.

Attention was called to the importance of having a converter and electric plug in an ambulance which plugs into the baby isolette and supplies electrical power for heating the isolette. High risk babies require heated isolettes during transportation. New ambulances have this as standard equipment, but many older ambulances do not. It was the consensus of the committee members that this information should be published in the KMA Journal.

A discussion developed regarding infant deaths in hospitals in which no reason is given for death. In view of this, a recommendation was submitted to the Board of Trustees that every hospital staff be urged to have a joint meeting between the pathologists, the pediatricians, and the obstetricians to study infant deaths in the hospital, to try to verify the cause of death and develop procedures that might avoid some deaths in the future.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS
Carlisle V. Dodson, M.D., Russellville
James B. Holloway, M.D., Lexington
Andrew M. Moore, M.D., Lexington
Donn L. Smith, M.D., Louisville
Charles B. Spalding, M.D., Bardstown
Tom Whayne, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

The reference committee reviewed the Report of the Council on Medical Education and Hospitals.

The outstanding work of this council is recognized, and their efforts are to be commended.

The work of the Advisory Committee to the Medical Schools has been outstanding, and they should receive the compliments of the entire Association.

The Report of the General Practice Committee is an outstanding report, and members of this committee are to be commended.

Reference Committee No. 2 wishes to compliment the Hospital Committee on their excellent work.

The reference committee wishes to compliment the Maternal Mortality Study Committee for their outstanding work during the present Associational year.

Reference Committee No. 2 wishes to recognize the outstanding work performed by the Perinatal Mortality and Morbidity Study Committee during the present Associational year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Resolution K

KMA Perinatal Mortality and Morbidity Study Committee

WHEREAS, the KMA Perinatal Mortality and Morbidity Study Committee has discussed the need for a home evaluation form for premature and high-risk infants as noted on page 15 of Report No. 12 to the House of Delegates, and

WHEREAS, such a three-part form would be utilized on a voluntary basis by hospitals for home follow-up visits of premature and high-risk infants by public health nurses, and

WHEREAS, the use of such a form would encourage mothers to seek physician care of the infant when they might not otherwise do so, and

WHEREAS, the distribution and usage of these forms on a voluntary basis with KMA approval would be a positive step by the Association in an effort to lower infant mortality and morbidity, and

WHEREAS, this form has already been approved by the Kentucky Chapter, American Academy of Pediatrics; Division of Maternal and Child Health, Kentucky State Department of Health; and the Public Health Nursing Service;

NOW THEREFORE BE IT RESOLVED THAT the KMA House of Delegates approves the use of the attached Home Evaluation Form for Premature and Other High-Risk Infants on a voluntary basis.

Recommendations, Reference Committee No. 2

Resolution K from the KMA Perinatal Mortality and Morbidity Study Committee was reviewed and discussed. Various opinions were heard, and Reference Committee No. 2 unanimously recommends the adoption of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution L

Jefferson County Medical Society

WHEREAS, many hospital and medical organizations have adopted resolutions urging physician memberships, with full suffrage equally with other members, on hospital boards of trustees or directors; and

WHEREAS, such boards of hospitals in the Louisville area and other areas in the Commonwealth of Kentucky are generally without physician representation; and

WHEREAS, physicians, by virtue of their education, training and experience, are expected by the public to know most about medical practice and patient care, and are likely assumed by the public to be members of such boards; and since physicians are acutely aware of hospital problems; and

WHEREAS, there is no more conflict of interest for the doctor than there is for any other member of the board; and

WHEREAS, many of the needs of the public for health care require closer physician-hospital partnership, and since physician representation on boards of trustees or directors has led to, and can lead to better communication and understanding between medical staffs and such boards; and

WHEREAS, physicians have served in positions of responsibility in community, civic, business and government projects with credit to these as well as to the medical profession; and

WHEREAS, it would be difficult to justify physicians not being major parties to making policies affecting medical practice and patient care in hospitals, leading to a very fair question: "How does the hospital board properly decide such matters without the physician?", therefore be it

RESOLVED, that the Kentucky Medical Association urge, encourage and request governing boards of all hospitals of the Commonwealth of Kentucky to provide means for election of physicians to such boards from membership of their respective medical staffs; and be it further

RESOLVED, that the Kentucky Medical Association urge, encourage and request that the medical staffs of all hospitals of the Commonwealth of Kentucky seek, by direct mediation and negotiation, an appropriate means to obtain election of physicians to boards of such hospitals, with full voting rights, as the most effective form of liaison between the medical staffs and hospital governing authorities.

Recommendations, Reference Committee No. 2

Resolution L from the Jefferson County Medical Society was reviewed. Various opinions were heard, and this committee unanimously recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 2 as a whole.

(Motion was seconded and carried.)

I wish to express my appreciation to the members of the committee for their patience and perseverance.

REFERENCE COMMITTEE NO. 2
Eugene H. Conner, M.D., Louisville
Chairman
Marion Douglas, M.D., Magnolia
C. C. Lowry, M.D., Murray
R. J. Salisbury, M.D., Mt. Sterling
Ralph G. Thomas, M.D., Leitchfield

REFERENCE COMMITTEE NO. 3

David A. Hull, M.D., Chairman

Report on Legislative Activities

Reference Committee No. 3 considered the following reports:

13. Report of the Council on Legislative Activities (State and National Affairs)

14. Report of the Council on Medical Services (Physical Medicine and Rehabilitation—Pages 18-30)

Resolution A—Therapeutic Abortion (Knox County)

Resolution B—Therapeutic Abortion (Whitley County)

Resolution C—Therapeutic Abortion (Mercer County)

Resolution E—Therapeutic Abortion (Meade County)

Resolution H—Professionalism in Laboratory Operation (Fayette County)

Resolution J—Blood Transfusions, Transplants and Related Matters (Fayette County)

Resolution M—Support of KEMPAC and AMPAC (Jefferson County)

Resolution O—Upgrading Qualifications for Licensure (Fayette County)

Report of the Council on Legislative Activities

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Legislative Activities is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committee of this Council with the Council recommendation following the committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

National Affairs

John C. Quertermous, M.D., Chairman

The Legislative Council on National Affairs met four times in regular session during the past year and in March met in Washington, D.C. in conjunction with the Legislative Key Men, KMA officers and staff, and Legislative representatives of some of the larger component societies. These representatives of the profession met and discussed medical legislation with their legislative counterparts. An "official" group consisting of the Legislative Council Chairmen, KMA Officers and Staff met with nearly all of the Congressmen and delved in some detail into our more immediate medico-political problems.

Kentucky is fortunate in having a Congressional delegation all of whom are extremely well versed in the problems of our country and with the Capitol Hill machinations that are necessary to give their impressions impact.

Your Council has kept in close contact with our Congressional delegation with respect to important legislation relating to health matters. These include:

1. The extension of the Keogh Act.
2. The bill introduced by Congressman John Watts clarifying "proposed regulation to tax net ad revenues of non-profit organizations."
3. The Medicare Amendments (H.R. 5710)
4. Communication with Congressman William Natcher on problems confronting his important Appropriations Committee.
5. Contact with the entire delegation regarding the determined efforts of cults to secure Federal funds for the "Kentuckiana Center for Education, Health and Research," formerly known as the "Kentuckiana Childrens Chiropractic Center." Applications amounting to as much as half a million dollars have been made and seriously considered by HEW. They are making concerted efforts to be included under PL 89-97.

This plus effort to keep abreast of AMA policy and to inform the KMA membership has kept your Council well occupied. A "box score" of the current status of significant legislation is appended to this report.

Because of the assumption of duties as KEMPAC Chairman, I feel it is necessary to resign, after many years, as your National Affairs Chairman and will take the liberty of editorializing briefly on the matters I feel are of major importance to us as citizens and physicians:

1. We must continue to show that the late President Kennedy's reference to Socialistic Europe as being enlightened thirty years ahead of the United States, in reference to medicine, is a false premise and one that the Wilbur Cohens can no longer use to justify his socialistic approach in his design of ALL MEDICAL LEGISLATION.
2. We must find some way to expose the amount of taxpayers' money that is being used by bureaucrats in lobbying for bills that are not intended to be for the welfare of the people but rather are designed to consolidate power and implement ingrained sub-bureaucratic philosophies. Many millions of unpublicized Federal dollars were spent by HEW and even other Federal departments in trying to sell Medicare (and other legislation) to the people and to the lawmakers.
3. We must evolve from an attitude of resistance (the AMA is showing the way) to an attitude that will enable us to recognize the problems that are bound to exist in the medical world and to take such positive steps at as local a level as possible to resolve them AT HOME before others have to look to the Federal Government for solutions to problems that should have been seen and remedied at our level.
4. We must accept our role of citizenship. Although this role necessarily carries the implication of participating in politics, I know it isn't degrading as many of us pretend. Is it too much trouble? It is especially important in this time, and even though we may occasionally find ourselves with strange bedfellows, the stimulation they will provide will make the effort worth our while.
5. We are being harried by laws made by regulation rather than by Congress after careful study of all the facets. This greatly increases the possibilities for political harrassment by department heads who may look with disfavor on certain segments of our society.

The Legislative Bulletin was published regularly and frequent use of it is made during the year to inform our members of important pending national legislation. This is a valuable publication mailed to KMA officers, key men and county medical society secretaries, and it is recommended that the information be used for a basis of discussion at county society meetings.

The Council reaffirms its belief in the objectives of KEMPAC and AMPAC and recommends 100% participation by doctors and their wives. We also recommend reaffirmation of KMA policy that there be county society billing in order to encourage this participation, and we finally recommend a vote of endorsement and encouragement by this House of Delegates of the KEMPAC organization to continue its worthwhile political efforts in the behalf of our free enterprise system and the freedom of the art and science of medicine.

RECOMMENDATIONS:

We recommend that the Washington Dinner be continued on a yearly basis.

We recommend that $100.00 be paid toward the expenses incurred by the members of the Council to the Washington Dinner.

Special thanks to the KMA staff for their contributions to this Council during the past associational year. Their assistance in both state and national legislative affairs has been most noteworthy and very much appreciated.

We would like to express our appreciation to the members of the Key Man System for their unflagging support and advice. We are grateful to the Board of Trustees and the House of Delegates for the confidence shown in allowing us to chair this important part of their organizational system.

I would like to thank the members of this Council for their unselfish contribution to the Association.

State Affairs

Fred C. Rainey, M.D., Chairman

The KMA Council on Legislative Activities has held four general committee meetings during the past year.

This being an "off year" during which the legislature did not meet, the effort of the Council has been directed primarily toward an awareness of potential and optimal legislation in the coming legislature in the primary and general elections. Considerable emphasis has been placed on studying the candidates and their philosophies.

Mailings have gone out to all county societies suggesting Public Affairs Programs patterned after those conducted in Jefferson and Warren Counties. Efforts have also been expended to strengthen the communicative procedures of the Key Man System.

A colored envelope has been adopted for mailings to all Key Men from the Chairman of the Council in an effort to call immediate attention to matters of pressing importance and also to enhance immediate response and action pertaining to these particular matters. The colored envelope is not used for routine mailing, but is used only during those instances which the Chairman feels demand immediate action. This enables the Key Man to immediately spot the blue envelope in his stack of daily mail so that he may open this mailing first rather than delay action.

Letters have been sent to all Senatorial Key Men, Representative Key Men and County Medical Secretaries in an effort to stimulate interest in the primary and in the general election. The President and Secretary of the KMA were requested to send a letter pertaining to these matters which was done, and a letter was also sent by the Chairman of the Legislative Council to all Key Men and County Society Secretaries. The first communication carried with it a survey form which the Key Men were to return to the Legislative Council informing the Council of the possible candidates and their strength and philosophy in their particular district. In these mailings, it was pointed out to the Key Men that in this election Kentucky would select candidates for Governor, State Offices, 20 State Senators and 100 State Representatives. It would stress that the makeup of the next General Assembly would be determined in the primaries.

In regard to Resolution "C", it is being handled by the Board of Trustees by a resolution at the House of Delegates.

The Council is on record supporting the position of the Louisville Chamber of Commerce and the Kentucky Farm Bureau in opposing the Uniform Time Act of 1966. This action has been approved by the KMA Executive Committee.

The Council has also gone on record favoring mandatory Measles Immunization Legislation and this has also been approved by the KMA Executive Committee.

The Legislative Council supports a proposal to introduce a bill which would prohibit the creation of new programs in Kentucky by simply appropriating the required amount of money in the State Budget. This also has been approved by the KMA Executive Committee, and study will be made as to the author of the bill and procedures to follow.

One of the most important recommendations made to the KMA Executive Committee as far as this Council is concerned is the recommendation that a full time staff member should be available for Legislative affairs. It is understandable that there are budgetary difficulties, but it is the feeling of this Council that additional personnel are severely needed during the General Assembly, the feeling being that we need at least two staff members during the entire period of the General Assembly working full time on Legislative Affairs and nothing else. It is noted that the KMA Executive Committee agreed in principle with the Council, but requested that this Council study ways and means of solving the problem of the budgetary difficulty. A dues increase is a logical solution to the problem confronting us. If it is the feeling that Legislative affairs is one of the most important areas for the profession and for the good of the general public, then more emphasis and funds must be expended in this area.

All proposed legislation emanating from individual physicians or groups of physicians should first be presented to this Council for study and review, and then, if approved, submitted to the General Assembly in unity. This would accomplish many purposes:

1. The Legislative Council would be aware at all times of pending legislation backed or introduced by members of this profession.

2. It would make it possible for this Council to appoint study committees to review and analyze the proposed legislation and to work out any possible amendments which would, in the end, strengthen the proposed legislation and enhance the possibility of its passage.

The Council on Legislative Activities has a number of recommendations to the KMA Board of Trustees. If these recommendations are accepted, the Council requests permission to include them as an addendum to their final report to the KMA House of Delegates.

A committee report of the Committee on Cults is included in this report.

Report of the Committee on Cults

David B. Stevens, M.D., Lexington, Chairman

The Committee on Cults, with five members as appointed by the KMA Board of Trustees, met on five separate occasions during the last year to date. These minutes of these meetings have been recorded and are in the Committee files. Attendance has been good at each meeting, except unfortunately Doctor Haley has been unable to attend. In addition, the Chairman attended the Congress on Medical Quackery sponsored by the American Medical Association in Chicago in October, 1966. The Chairman has also had numerous consultations with the officers and staff of KMA regarding problems related to cults.

Through the year, the Committee has maintained surveillance of the status of chiropractic and cult advertising in public media in Kentucky. It has also informed the physicians of the State, through obtainment of AMA pamphlets and display of an AMA Department of Investigation booth at the KMA Annual Meeting in September, 1966. In preparation now is an article for the Journal and continued material for the Communicator. No public program of education has been planned. Physician ignorance and apathy concerning this problem remain.

The second major activity of the Committee has been its concern with the Kentuckiana Center for Education, Health and Research. This chiropractic sponsored facility in Louisville has broadened its activities and now concentrates primarily on the problem of mental retardation. In support of the mental retardation program, this group has approached public and private agencies on a local, state and national level. Only by concerted effort of alert individuals have significant grants to this institution been prevented.

The Committee has also functioned to maintain liaison with the AMA Committee on Quackery, and the Chairman has attended several meetings of the Quackery Committee.

The problem of cult practice or chiropractic is essentially a political problem. In an effort to create a better stage for fruitful political activity, the Committee held a joint meeting with the department heads of various state agencies in Frankfort on February 8. At that time, the position of the medical society was explained, but in addition, acquaintances were made and hopefully alliances were established.

The Committee has recommended a legislative program for consideration of the KMA Council on Legislative Activities and KMA Board of Trustees.

This Committee was enlarged from three men to five to provide a better geographic coverage of the State. This impedes meeting facility and apparently attendance. I think, however, continuation of the same Committee for another year would be desirable, if the members would serve.

Our next year will be concerned with the preparation of the bills and lobbying against passage of cult-supported legislation.

Addendum to the Final Report of the Council on Legislative Activities

Since the Final Report of the Council on Legislative Activities was prepared, a number of actions have taken place which we believe should be reported to you by means of this addendum to our report.

National Affairs

John C. Quertermous, M.D., Chairman

Concerning the relationship between Medicine and Optometry, the Board of Trustees has adopted as KMA policy the AMA position which urges constituent medical societies to oppose, as detrimental to the public inrteest, any proposed legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury of the eye.

The Board has also adopted as KMA policy the position of the AMA on the relationship of Medicine and Osteopathy which points out that the primary issue at this time appears to be one level of medical education and practice as opposed to another and lower level, and supports the AMA action that negotiations begin promptly toward the beginning of official change of Schools of Osteopathy to Schools of Medicine.

At the time this addendum was written, the House of Representatives had passed H.R. 12080 covering the Social Security Amendments of 1967. This legislation closely follows the recommendations of AMA and your Council on Legislative Activities. It is hoped that this portion of the bill will be passed by Congress in the original form without amendments.

State Affairs

Fred C. Rainey, M.D., Chairman

A sound and functioning key man system is one of the most important resources of the Association. We are most grateful to the many physicians who have served so well in this capacity. It is a year-around job with a close friendly relationship with legislators and candidates a necessity. Since there will be many new legislators this year, a number of new key men will need to be selected and Orientation Programs developed. The Legislative Council has secured approval from the Board of Trustees to use a more flexible approach in the selection of key men this year in an effort to secure the best key men available. It is urged that if you are requested to serve that you accept this vital assignment.

The Council is keeping a close watch on legislation introduced in other State Legislatures and has under study a number of legislative proposals suggested for introduction in the 1968 Kentucky General Assembly.

The Council endorses in principle the 1966 Medical Examiners' Bill (so-called Coroners' Bill) and has Board approval to set in motion the necessary mechanics for the drafting of such proposed legislation.

In connection with any proposed legislation, it should be reiterated that there is much more involved in the passage than the mere drafting of a bill or a promise by a Legislator to introduce the legislation. We will need physicians who will be willing to secure home town support of their legislators; seek support of allied and interested groups; and be willing to visit the Legislature and appear before committee hearings.

We will continue to support health and medical legislation in the best interest of the people of Kentucky and oppose that which is not. The help of all physicians in Kentucky to work toward these goals will be needed.

KMA COUNCIL ON LEGISLATIVE ACTIVITIES
B. B. Baughman, M.D., Frankfort
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
David Hull, M.D., Lexington
W. Fielding Rubel, M.D., Louisville
John C. Quertermous, M.D., Murray, Chairman, National Affairs
Fred C. Rainey, M.D., Elizabethtown Chairman, State Affairs

Recommendations, Reference Committee No. 3

The report of the Council on Legislative Activities was reviewed. This report was divided into two parts, a) National Affairs by Doctor John Quertermous and b) State Affairs by Doctor Fred Rainey.

The Committee recommends that the report of the Council on Legislative Activities, National Affairs, be adopted and implemented as outlined by Doctor John Quertermous. This Committee wishes to commend Doctor Quertermous for his untiring, zealous pursuit of his duties as national chairman during these most trying years and to wish him success as the new Chairman of KEMPAC.

The Committee recommends that the report of the Council on Legislative Activities, State Affairs, be adopted and implemented as outlined by Doctor Fred Rainey with special emphasis on page 7, paragraph 2, which reads: "One of the most important recommendations made to the KMA Executive Committee, as far as this Council is concerned, is the recommendation that a full time staff member should be available for Legislative affairs. It is understandable that there are budgetary difficulties, but it is the feeling of this Council that additional personnel are severely needed during the General Assembly, the feeling being that we need at least two staff members during the entire period of the General Assembly working full time on Legislative Affairs and nothing else. It is noted that the KMA Executive Committee agreed in principle with the Council, but requested that this Council study ways and means of solving the problem of the budgetary difficulty. A dues increase is a logical solution to the problem confronting us. If it is the feeling that Legislative affairs is one of the most important areas for the profession and for the good of the general public, then more emphasis and funds must be expended in this area." The Committee recommends that in order to implement this section of the report, there be a $5.00 per year dues increase to all Active members of the KMA. This money is to be earmarked for legislative activities, specifically for the employment of a full time staff member and an additional staff member at the time of the General Assembly. This, of course, would require an editorial change in the By-Laws, Chapter 9, Section 1, which we recommend.

Mr. Speaker, I move the adoption of this section of the report.

In the discussion that followed this motion, the legal counsel explained that this was a Bylaw change and that Bylaw changes must lay on the table for 24 hours, unless the rules are suspended which requires unanimous approval by the delegates in attendance. After further discussion, a motion was made, seconded and carried that the rules be suspended.

(Following this action, motion to adopt the report was seconded and carried.)

(The following committee report was split from the Council on Medical Services, the main report having been referred to Reference Committee # 4.)

Physical Medicine and Rehabilitation Committee

W. K. Massie, M.D., Lexington, Chairman

This committee met on November 23, 1966, to outline the objectives for this Associational year and to review the recommendations of previous years. A second and final meeting of the committee was held on May 4, 1967. At the initial meeting it was the concensus that the main objective of the committee for the year 1967 was to seek recommended changes in the Workman's Compensation Law in Kentucky, to motivate impaired people to go back to work within their capability of impairment thus promoting on their own volition a measure of economic independence and less dependence on public support. Meetings of this committee in previous years recognizing the considerable litigation experienced in compensation cases had emphasized the importance of establishing a yardstick for the measurement of functional impairment and disability in an effort to standardize these evaluations among various medical observers throughout the state. In fact, a subcommittee of this committee dealing with this specific item had been appointed. After a detailed and lengthy discussion on this problem outlining in skeletal form the framework of the endeavors of the subcommittee, it became apparent that there was such little unity among the members of the parent committee on even how to approach this problem that efforts in this direction should be at least postponed. Efforts of the committee would be concentrated on formation of a broad outline of suggested alterations in the present Workman's Compensation Law which would be helpful in proposed meetings of the Department of Labor and of management regarding this subject in time to formulate a suggested constructed revision of the law for consideration by the 1968 legislature.

In the study this year, the committee sent representatives to a meeting held by the Commission of Labor of Kentucky to discuss revision of the Kentucky Workman's Compensation Law. Representing the committee were: William K. Massie, M.D., Lexington, Chairman; and Joe E. Warren, M.D., Lexington, Chief of Rehabilitation at the University of Kentucky. Other members at the meeting invited by Commissioner Cabe were Mr. Keller Whitaker, Director of Workman's Compensation; two members of the Vocational Rehabilitation, Mr. Minnic and Mr. Flagey; Mr. Al Trig, member of the Workman's Compensation Board; two members of the United Mine Worker's Welfare Fund, John Winebrenner, M.D., and James Salyers; Mr. Terrance Carroll, Director of the National Institute of Rehabilitation, a volunteer agency in Washington, D. C. At the conclusion of this meeting it seemed generally agreed that there were needed revisions in the Kentucky Workman's Compensation Law. Many of the points brought out by Mr. Carroll as being long operating in other states were not applicable under the present Workman's Compensation Law in Kentucky. It was agreed that the points of discussion in this meeting would be summarized, digested and a second meeting held early in 1967 to outline specific recommended alterations. The Rehabilitation Committee held its final meeting on May 4, 1967. It seemed obvious to the committee that the Workman's Compensation Law as currently written was not concerned with rehabilitation and ultimate retraining and re-employment of workers unable to return to their original occupation. It is just such patients who frequently gravitate to the roles of welfare services or apply for disability awards under Social Security prematurely.

DIVIDED RESPONSIBILITIES

Under current administration and law, Workman's Compensation is a responsibility of the Department of Labor. Vocational Rehabilitation, however, is a responsibility of the Department of Education. Still other educational and training services fall under the Department of Economic Security. While there may be cross coordination on some cases in the rehabilitation training of some individuals, it is the feeling of this committee that much more could be accomplished if rehabilitation and retraining of a disabled worker began simultaneously with his treatment for injuries under the Workman's Compensation Law; and further, that an improvement in administration might be accomplished if rehabilitation and vocational training were the joint responsibility of the same department which administered Workman's Compensation. The importance of simultaneous application of remedial and rehabilitative services so that injury to a part does not effectively immobilize the whole man and reduce his work tolerance to a fraction of his previous status is of prime importance. Under the present framework of the law, this is not only impossible, but factors in opposition to this objective seem accentuated.

Furthermore, during the course of this study the absence of meaningful statistics has proved to be quite a hardship in developing sound recommendations and suggestions for improving the administration of Workman Compensation claim cases and rehabilitation and training of the individual. If these two functions, the administration of Workman's Compensation Law and the rehabilitation and training services, were administered by the same department, meaningful statistics could be accumulated, which if summarized in table form periodically, could serve as signposts for recommended improvements and periodic revisions of the law to keep abreast of the constantly changing working conditions within the Commonwealth.

This committee would like to present both general and specific recommendations relative to the present Workman s Compensation Law.

GENERAL RECOMMENDATIONS

1. *Litigation as a barrier to rehabilitation*

   Issues which give rise to litigation and which require administrative or judicial decisions in Workman's Compensation cases can be grouped into two broad categories.

   a. Those issues normally raised by the insurance carrier which relate to the causal factor of a given disability and its relation to the patient's work.

   b. The question of the nature and extent of the existing disability. What percent of disability was pre-existing and what percent directly resulted from the alleged injury? Also is a partial disability rendering the worker unable to return to his original occupation tantamount to total disability? Should the determination of permanent disability be primarily the expression of the existing permanent functional impairment in relation to extenuating variable conditions such as age, education, influence of the safety of the worker in performing future labor, etc., or should this disability be primarily oriented to the type of work and its attended salary for which the worker could be expected to compete on the work market? The litigious atmosphere resulting from these issues effectively stultify any rehabilitation effort until they have been settled in or out of court, a procedure which may require years to consummate. In the meantime, the patient's work tolerance progressively deteriorates so that when he is ultimately faced with the problem of rehabilitation, re-training and re-employment or acceptance of a monetary dole in the form of welfare and Social Security hand-outs, only the latter alternative can be seriously entertained. In contrast, however, if the administrative agencies assume a close supervisory role, the worker could not be coerced into premature "cash settlements" to relieve current grocery bills and the worker's attention

could be occupied with the problem of attaining maximum physical fitness through rehabilitation provided concurrently with any remedial treatment. Remuneration should, during this period of rehabilitation, be increased with each demonstration of a decreased percent of functional impairment thus offering a bonus for demonstrated cooperation in rehabilitation which is in contrast to the present tendency to demonstrate maximum dependency in order to obtain the largest possible cash award. On the other hand, any demonstration of non-cooperations in rehabilitation offered should result in monetary decreases, and refusal to participate in rehabilitation recommended by the physician in charge should result in cessation of all compensation payments temporarily. This, however, requires interagency cooperation because if, as the compensation payments should be decreased, the welfare payments are increased, the overall effect would be a decrease in incentive to rehabilitation.

This committee recommends in all cases regardless of controversy over liability or extent of disability:

1. Rehabilitation should commence immediately without reference to eventual fixing of liability.
2. A fund should be established which would provide for initial payment for medical and rehabilitation services in controversial cases. This fund is to be supported either by governmental appropriation or through an insurance policy held jointly by employer and employee.
   a. The employer or carrier, if eventually held liable, should reimburse the fund for expenditures on behalf of the worker. Should the condition prove unrelated to work, the insurance taken for this would reimburse the fund.
3. Legal fees should be computed so that they have the best possible effect on the provision of medical and rehabilitation services.
4. No disability should be rated until after the Workman's Compensation Agency finds that the worker has achieved maximum rehabilitation and has returned to a gainful occupation for no less than three months.
5. No lump sum settlement should be allowed and no individual should be allowed to compromise his rights to full medical care under a compromise and release settlement unless the Workman's Compensation Agency approves such a settlement on the advice of the state Vocation and Rehabilitation Agency or the rehabilitation unit in the Workman's Compensation Agency. The reasons for allowing such a settlement should be specified by its terms.

ON THE JOB REHABILITATION

This committee unanimously agreed that while organized rehabilitation departments could initiate rehabilitation particularly during the period when remedial treatment is still in progress, final rehabilitation must be provided with the patient actually on the job. This committee realizes there is a general feeling of the employer against returning workers to their jobs on a trial basis. In many cases employers have already hired and trained someone else whom they are sure can fill the job. They are also hesitant to re-employ a worker with a condition which might subsequently be accentuated and brought again into reality by the work demanded. At the same time, workers fear that a too early return to work and too great a demand by the work supervisor will result in reaggravated symptoms which would demand repeated cessation from work and would mitigate against his future re-employment. For this contingency the present Workman's Compensation Law provided Section 342.100 which the committee felt if operational would function admirably to stimulate rehabilitation of the worker on the job. This provides that the employer pay the worker in proportion to the actual work accomplished, but the carrier would supplement his salary up to two-thirds of the difference between the present salary and his salary at the time of injury. To the knowledge of the committee, this section is rarely implemented even when its implementation has been suggested in the doctor's report.

This committee, therefore, recommends that:

1. The temporary income benefits should be provided under statute during the entire period of rehabilitation, this benefit to fluctuate proportionate to the demonstrated cooperation of the worker in rehabilitation. In addition, special living expenses and all other costs incidental to the disabled worker's rehabilitation should be provided.
2. After a plateau of improvement provided by rehabilitation, permanent disability benefits should be provided for anatomical and functional loss only.
3. In addition, if the functional impairment results in a permanent wage decrease, a table of income benefits should be provided to compensate the worker during the total period of disability.
4. Consideration should be given to all programs considered and those to be considered in the future which provide inducement for the employer to encourage the rehabilitation and re-employment of the injured worker with specific augmentation of section 342.100 of the existing law.

STATUTORY LIMITATIONS

In a sense, all barriers to rehabilitation under Workman's Compensation flow from statutory limitations. The prime concerns of this committee, however, are the statutory limitations which flow from medical care provisions, the time limitations on the filing of claims for compensation and the problems which arise from the operation of subsequent injury funds.

The medical files are replete with compensation cases who received less than optimum initial treatment, little or no rehabilitation, were persuaded or coerced into accepting a cash settlement and who were subsequently dropped from the files of the insurance carrier to be deposited on the welfare list as wards of the state. This committee believes the law should provide for and protect these individuals so that they may get the required medical treatment they need at the time it is initially needed together with optimum rehabilitation. The committee has noted that the wishes of the individual in the choice of the treating physician are rarely if ever heeded, but that on many occasions the patient, convinced that his condition is not work related, seeks out inferior medical treatment at his own expense.

The committee makes the following recommendations:

1. Workman Compensation laws should include adequate provision for broad subsequent injury funds.
2. Full medical benefits as may be reasonable should be required at the time of injury and at any time thereafter to cure or relieve the effect naturally resulting from the injury and to hasten the injured worker's return to employment, and should be provided under the Workman's Compensation Law. Such medical benefits should include full medical care, all necessary related services, (including drugs ordered by the treating physician), original and replacement appliances, and should also include specific reference to and provisions for rehabilitation in all its phases, including vocational rehabilitation.
3. Notification of rights under the law should be sent immediately to each patient explaining in detail the intent of compensation awards for permanent impairment. (Here it should be made clear to the patient, as expressed in the

previous paragraph, that cash compensation is made for functional impairment. Additional compensation resulting from a decreased salary is, however, dependent on some salary. Should the patient forego the opportunity provided for retraining, relocation and re-employment in a different job status with a lowered tolerance, he would have no claim to the augmentation of his salary provided by the decreased earning power resulting from his injuries).

4. Each jurisdiction should assure itself that the statutory limitations on the time within which a claim must be filed, or within which a claim can be re-opened, do not bar claims of employees for latent injuries and diseases.

THE KENTUCKY WORKMAN'S COMPENSATION LAW

This committee suggests that the name of the law itself should be changed from Kentucky Workman's Compensation Law to Kentucky's Workman's Compensation, Rehabilitation and Re-training Law.

Section 342.020—Medical Treatment and Expense of Employer; Artificial Members and Braces.

This committee recommends the law should require the employer to shoulder the responsibility of treatment asd rehabilitation as well as compensation of the disabled worker. Rehabilitation should be spelled out as a normal requirement and component part of medical treatment. Retraining, relocation and re-employment, however, should not be the sole responsibility of the employer. At present the state already provides these services for the worker who, through changing work conditions in the area, requires them. These same services should be extended to the disabled worker. Nevertheless, to provide an impetus for reutilization of the employer's own previous workers, he should participate in the additional expense of retraining, relocation and re-employment in another field should this become necessary. The employer should be required to maintain a plant panel of qualified physicans from which he and/or the injured employee may select a physician. Presumably the selection would be agreeable to both parties.

Section 342.150—A Lump Sum Compensation: When and How Made

A lump sum settlement may work toward the detriment of the rehabilitation of a disabled worker. Occasionally, a man may have already made a lump sum settlement before a doctor makes a conclusive rating or a definite decision about his impairment. This committee believes it should be a requirement of the law that the Workman's Compensation Board supervise and oversee the settlements under this section. The law should protect the uninformed injured worker in this section to keep him from being deprived of the right through premature lump sum settlement. In all cases, lump sum settlements should not be allowed for three months. The committee recommends that no lump sum settlements be allowed until it is approved by the Workman's Compensation Board.

Section 342.100—Compensation for Partial Disability.

Believing that this section of the law is largely ignored, the committee invites the attention of enforcement officials to it. It affords an unparalleled opportunity for the employer to participate in the on-the-job rehabilitation of his previously injured employee. The employer must be adequately protected, however, against additional claim by the employee for any augmentation of his symptomatology while under this program. Should the employer be unable to provide further work opportunity for a partially disabled worker, he should participate in the expense of retraining, relocation and re-employment of the employee.

COORDINATION OF THE WORKMAN'S COMPENSATION SYSTEM WITH OTHER WAGE LOSS BENEFIT SYSTEMS

As a matter of policy, it is felt that all public assistance providing benefits upon interruption or termination of earnings should be viewed as related parts of a general public system for providing protection against wage loss. To the extent that such plans are not entirely contributory, duplication of wage loss benefits for the same period of wage loss should be avoided. Not to do so is to put a premium on *not* working, in some cases making idleness actually more remunerating than industry with other wage loss benefit systems. As a matter of policy it was felt that all public assistance providing benefits from interruption or termination of earnings should be viewed as related parts of general public systems for providing protection against wage loss. For example, an injured worker receiving compensation payments may in the seventh month after injury, if expected to remain unemployed for a year, be eligible for Social Security benefits administered under the Department of Economic Security. Also under the supervision of another section of the same department his family may be eligible for food stamps and his child for aid to dependent children. In this connection, the committee recommends that in the formulation of changes in the present compensation law, consultation with the directors of each department concerned with wage loss benefit systems may obviate at the outset many of the inequities and duplications which can never be satisfactorily solved by interdepartmental consultation later at lower eschelons.

The committee suggests that this report be made available to the groups representing labor, employment and insurance carriers; that these groups formulate a similar proposal of suggested alterations in the Workman's Compensation Law and that all components then meet early in the fall to formulate a work committee to draw up these suggested changes and to suggest a sponsor in the House of Legislature. Previously, the Executive Committee of the Kentucky Medical Association indicated that, while it was acutely concerned with this aspect of medicine and would hold itself in readiness to give professional medical advice, it did not wish to be the absolute leader of this effort.

The committee requests that the Executive Committee append to this report its current opinion on this subject. It also requests that if it is in agreement with this report, that it authorize legal and lobbying aids necessary to bring this before the 1968 House of Legislature in a form calculated to result in fruition of its aims.

Recommendations, Reference Committee No. 3

Report No. 14 on the Council on Medical Services was divided between committees. Reference Committee No. 3 dealt with the report of the Committee on Physical Medicine and Rehabilitation, whose Chairman was Doctor W. K. Massie. This report includes pages 18-30 and deals with the proposed changes of the Kentucky Workman's Compensation Law.

The Committee recommends the adoption and implementation of the report by the Committee on Physical Medicine and Rehabilitation and commends Doctor W. K. Massie for his work in this field.

In accordance with instructions of the Board of Trustees, the Committee heard a report of the KMA legal counsel on this matter and recommends that the Association take the lead in attempting to secure agreement from all interested parties which would lead to the enactment of the desired legislation at the 1968 session of the General Assembly.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)



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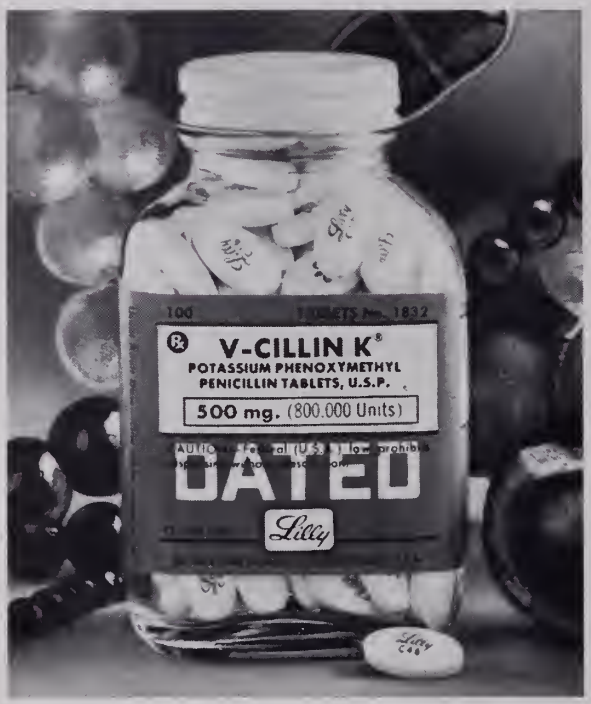
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Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

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Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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(Resolutions A, B, C, and E related to the subject of Therapeutic Abortion. Reference Committee No.3 considered these four resolutions as a group and made a single motion concerning them.)

Resolution A

Knox County Medical Society

WHEREAS, the law pertaining to therapeutic abortion in the Commonwealth of Kentucky is archaic, having been enacted about one hundred years ago, and

WHEREAS, we are in the 7th decade of the 20th century and our citizens ought to be able to avail themselves of modern medical knowledge, and

WHEREAS, in 1959 the American Law Institute wrote and recommended a model law pertaining to therapeutic abortion that is approved by the American College of Surgeons and the American College of Obstetrics and Gynecology, and

WHEREAS, at least seven states and the District of Columbia have enacted modern laws pertaining to abortion with 22 other states now considering such laws and 15 states discussing statute changes to modernize their laws, only Kentucky with a few other states yet remaining to act, and

WHEREAS, it would not infringe upon the religious choice of any group as no one would be required to utilize the terms of such a law, and no hospital or institution would be required to admit patients who choose, with the required medical advice, to utilize the provisions of this law, and

WHEREAS, the American Medical Association has recently taken an unequivocal stand in favor of liberalizing the abortion laws,

NOW THEREFORE BE IT RESOLVED, by the Delegates of the Kentucky Medical Association that we instruct the Legislative Council of KMA to sponsor a modern therapeutic abortion law for Kentucky and urge all legislators to act favorably on this legislation which would not only modernize, but also would humanize the law pertaining to therapeutic abortion.

Resolution B

Whitley County Medical Society

WHEREAS, the law pertaining to therapeutic abortion in the Commonwealth of Kentucky is archaic, having been enacted about one hundred years ago, and

WHEREAS, we are in the 7th decade of the 20th century and our citizens ought to be able to avail themselves of modern medical knowledge, and

WHEREAS, in 1959 the American Law Institute wrote and recommended a model law pertaining to therapeutic abortion that is approved by the American College of Surgeons and the American College of Obstetrics and Gynecology, and

WHEREAS, at least seven states and the District of Columbia have enacted modern laws pertaining to abortion with 22 other states now considering such laws and 15 states discussing statute changes to modernize their laws, only Kentucky with a few other states yet remaining to act, and

WHEREAS, it would not infringe upon the religious choice of any group as no one would be required to utilize the terms of such a law, and no hospital or institution would be required to admit patients who choose, with the required medical advice, to utilize the provisions of this law, and

WHEREAS, the American Medical Association has recently taken an unequivocal stand in favor of liberalizing the abortion laws,

NOW THEREFORE BE IT RESOLVED, by the Delegates of the Kentucky Medical Association that we instruct the Legislative Council of KMA to sponsor a modern therapeutic abortion law for Kentucky and urge all legislators to act favorably on this legislation which would not only modernize, but also would humanize the law pertaining to therapeutic abortion.

Resolution C

Mercer County Medical Society

WHEREAS the law pertaining to therapeutic abortion in the Commonwealth of Kentucky is archaic, having been enacted about one hundred years ago, and

WHEREAS we are in the 7th decade of the 20th century and our citizens ought to be able to avail themselves of modern medical knowledge, and

WHEREAS in 1959 the American Law Institute wrote and recommended a model law pertaining to therapeutic abortion and it has been approved by the American College of Surgeons and the American Medical Association, and

WHEREAS at least seven states and the District of Columbia have enacted modern laws pertaining to abortion wtih 22 other states now considering such laws and 15 states discussing statute changes to modernize their law, only Kentucky with a few other states yet remains to act, and

WHEREAS it would not infringe upon the religious choice of any group as no one would be required to utilize the terms of such a law, and no hospital or institution would be required to admit patients who choose, with the required medical advice, to utilize the provisions of this law,

NOW THEREFORE, BE IT RESOLVED THAT The House of Delegates of the Kentucky Medical Association go on record as favoring the concept of modernization for the Abortion Law in Kentucky, and

BE IT FURTHER RESOLVED that in keeping with the action of the AMA House of Delegates in June, 1967, it may be considered consistent with the principles of medical ethics for a physician to provide medical information to State Legislators as they consider new abortion legislation.

Resolution E

Meade County Medical Society

WHEREAS there has been no review of the laws in Kentucky either by the Kentucky Legislature or the Kentucky Medical Association in modern times, and

WHEREAS the Meade County Medical Society strongly feels that such a study is long overdue and that it is in the best interest of the patient, the public, and the physician, that such a study be undertaken;

NOW THEREFORE BE IT RESOLVED THAT the Kentucky Medical Association authorize the Council on Legislative Activities to draft amendments to the present law on abortion, modeled after the AMA action at its June annual meeting in 1967 for approval by the KMA Board of Trustees,

AND BE IT FURTHER RESOLVED THAT on the approval of the proposed legislation by the Board of Trustees that it cause this bill to be introduced into the 1968 session of the Kentucky legislature.

Recommendations, Reference Committee No. 3

Resolution A introduced by Knox County Medical Society and Resolution B introduced by Whitley County Medical Society deal with therapeutic abortion. These two resolutions were so stated to instruct the Legislative Council of KMA to sponsor modern therapeutic abortion laws in Kentucky.

Resolution C introduced by Mercer County Medical Society also dealt with therapeutic abortion and recommended modernization of the abortion law in Kentucky pointing out that, in keeping with the AMA House of Delegates, it was considered con-

sistent with the principle of medical ethics for a physician to provide medical information to state legislators.

Resolution E introduced by Meade County Medical Society and also dealing with therapeutic abortion recommended that the Council on Legislative Activities draft amendments to the abortion law modeled after the AMA action and that, upon approval of the Board of Trustees, it cause a bill to be introduced into the 1968 session of the Kentucky legislature.

Reference Committee No. 3 recommends that neither Resolutions A, B, C, or E be adopted. It was the feeling of this Committee that it go on record favoring the position of the AMA House of Delegates taken on this subject in June 1967. However, it is recommended that KMA not assume the responsibility of sponsoring legislation to modernize Kentucky's abortion law.

Mr. Speaker, I move the adoption of this section of the report.

(Following discussion, motion was seconded and carried.)

Resolution H

Fayette County Medical Society

WHEREAS, throughout the United States there are springing up increasing numbers of laboratories which are without physician direction, and

WHEREAS, the operation of medical or clinical laboratories has repeatedly been defined by the American Medical Association and other medical groups as the practice of medicine, and

WHEREAS, there are currently attempts in the United States Congress to pass legislation requiring licensure of laboratories, and

WHEREAS, physician direction of laboratory facilities tends to assure ethical operation and maintenance of quality;

NOW THEREFORE BE IT RESOLVED THAT the Kentucky Medical Association be requested to work with interested medical and paramedical groups in the development of legislation to be presented to the next Kentucky Legislature which will assure professionalism in laboratory operation by placing the operation of these facilities in the hands of the physician.

Recommendations, Reference Committee No. 3

Resolution H on Professionalism in Laboratory Operation was introduced by Fayette County Medical Society. The Committee recommends the adoption and implementation of Resolution H regarding professionalism in laboratory operation, but recommends that the final decision regarding development of legislation be under the direction of the Council on Legislative Activities.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Resolution J

Fayette County Medical Society

WHEREAS, blood for transfusion is human living tissue and is not a commodity; blood does not carry an expressed or implied warranty; blood used for transfusion is a service; and blood is an integral part of the rendition of medical services to the individual,

THEREFORE BE IT RESOLVED THAT the Kentucky Medical Association urge the State Legislature to enact legislation in a statute incorporating the principle that the procurement, processing, distribution or use of whole blood, plasma, blood products, blood derivatives and other human tissues such as corneas, bones or organs for the purpose of injecting, transfusing or transplanting any of them into the human body is declared to be, for all purposes, the rendition of a service by every person participating therein. It is declared not to be a sale or barter but shall be considered a medical service whether or not any remuneration is paid therefor.

Recommendations, Reference Committee No. 3

Resolution J on Blood Transfusions, Transplants and Related Matters was introduced by Fayette County Medical Society. The Committee recommends the adoption and implementation of this Resolution, but that the final decision regarding development of legislation rest in the hands of the Council on Legislative Activities.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Resolution M

Jefferson County Medical Society

WHEREAS, past experience and results have shown KEMPAC and AMPAC to be effective instruments in the armamentarium of medicine's effort to better the public health and present quality care; and

WHEREAS, the most satisfactory results in behalf of all interested parties can best be obtained when all participate, are knowledgeable and feel the need; and

WHEREAS, for the best in legislation you must support the best candidate; and

WHEREAS, for responsible and successful results they who give and work best will be best rewarded for their efforts; therefore be it

RESOLVED, that KMA commend and endorse the past efforts of KEMPAC and AMPAC and encourage and beseech all doctors to participate and give as never before in order that these most necessary activities be allowed to grow and expand and to be even more effective as a result of such support.

Recommendations, Reference Committee No. 3

Resolution M on Support of KEMPAC and AMPAC was introduced by Jefferson County Medical Society. The Committee recommends the approval of Resolution M as submitted by the Jefferson County Medical Society.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Resolution O

Fayette County Medical Society

WHEREAS cult practices continue to be a major public health problem in Kentucky, and

WHEREAS state licensure is the only method of effective control,

THEREFORE BE IT RESOLVED that the Legislative Council of the Kentucky Medical Association provide for introduction and seek passage of a bill which would require practitioners of medicine, dentistry, podiatry, osteopathy, and chiropractic, to have successfully completed two years of accredited preprofessional college as a qualification for state licensure.

Recommendations, Reference Committee No. 3

Resolution O on Upgrading Qualifications for Licensure was introduced by Fayette County Medical Society. The Committee recommends the approval of Resolution O regarding upgrading qualifications for licensure.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 3 as a whole.

(Motion was seconded and carried.)

The Chairman wishes to thank the members of Reference Committee No. 3 for their work.

REFERENCE COMMITTEE NO. 3
David A. Hull, M.D., Lexington, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
Clyde T. Moore, M.D., Fern Creek
Norma Shepherd, M.D., Hopkinsville

REFERENCE COMMITTEE NO. 4

W. Fielding Rubel, M.D., Chairman

Reports on Public Service and Medical Services

Reference Committee No. 4 considered the following reports:

14. Report of the Council on Medical Services, Pages 1-17
15. Report of the Council on Communications and Public Service
25. Report of the Board of Directors of Kentucky Physicians Mutual, Inc.
28. Report of the Ad Hoc Study Committee for Improved Community Health

Resolution G—The Ethics of Individual Responsibility

Resolution P—Co-Sponsorship with the Kentucky TB and Respiratory Disease Association of Health Messages Pertaining to Tuberculosis for Outdoor Billboard Advertising with Cost to be Assumed by TB Association.

Report of the Council on Medical Services

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*
2. *Reports of the committees of this council with the council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

Your Council on Medical Services met three times during this Associational year, November 17, 1966, February 9 and June 15, 1967.

Most of the time consumed by the council members during these council meetings was in hearing reports, making referrals, or taking action on recommendations being made by the committees serving under the council. These matters are reported on by the committees, so we will not elaborate on them in this section of the report.

As the Council on Medical Services, we did discuss to some extent such activities as the KMA fee survey, Ad Hoc Committee to Study Health Services in Kentucky, socio-economics of health care, and the Ad Hoc Committee to Study the Reorganization of KMA.

Our council members were in full agreement with the need for studying KMA reorganization. It was our recommendation to that committee that the council system be discontinued in the KMA organization structure. There were many reasons for this, which may be noted in the Report of the Chairman of the Board of Trustees. While the council system is good in principle, it just does not function effectively as a practical matter and has a tendency to stifle committee activity and timely completion of KMA programs.

Your council has had the responsibility of KMA's physician placement service; and since the guidelines for this program have been formulated for staff implementation, no changes were deemed necessary this year. We were pleased that one of our council members, Walter L. O'Nan, M.D., Henderson, could attend the AMA Socio-Economic Conference last January and report on the proceedings to us.

We are grateful to the chairmen of the committees serving under this council. Their reports, with council action, are as follows:

Advisory Commission to Blue Shield

W. Vinson Pierce, M.D., Covington, Chairman

The KMA Advisory Commission to Blue Shield met this year on May 4. The purpose of the Commission, its activities, the history of Kentucky Physicians Mutual (Blue Shield) and its relationship with KMA were presented for informational purposes. We are proud of the relationship that has existed between Blue Shield and the medical profession in Kentucky, and it is our desire to maintain a continuing liaison as a part of our responsibility.

After reviewing our report to you last year, the Commission members discussed the statement (which had been referred to us) endorsed by the House relating to the 1966 Report of the Kentucky Physicians Mutual which in part stated:

"a. That no other Blue Shield coverage is available to this age range (over 65).

b. That the coverage which is available under this plan (over 65 Blue Shield Plan) is somewhat limited.

c. That there is evident need for better explanation to patients of the limitations of such coverage.

In addition, it was recommended that consideration be given . . . to studies which may lead to the possibility of more effective coverage for patients in this age range, as a supplement to the Medicare Law."

Members of the Commission generally felt that last year's Reference Committee Report No. 5 (which contained the above statement) was based somewhat on misinterpretations and without full understanding of the "Over 65 Blue Shield Plan." However, it is acknowledged that there is a communications problem with this particular age group, and the Medicare Law plays a significant role in this confusion.

In response to statements a, b, and c, above, we feel it to be pertinent to report to you that:

1. (In reply to a.) Blue Shield did not arbitrarily cancel an over age 65 subscribers contract. They were continued on their current contracts if they chose to not transfer to Blue Cross-Blue Shield 65 program.
2. (In reply to b.) The "Over 65" plan was designed to fill in the Medicare gaps and result in better coverage rather than a "limited coverage." The $100 deductible in effect last year has been reduced to $50 deductible (giving more complete coverage), but we do not feel it wise to eliminate or reduce this deductible any further.
3. (In reply to c.) We have previously mentioned the communications problem but wish to report that efforts have been made during the past year

to better inform the Blue Shield member. The communications barrier is under constant pursuit, and new approaches are being planned for implementation.

Blue Shield staff members, guests at our meeting, presented a most encouraging report on current and scheduled activities and programs.

We are now approaching one million Blue Shield members in Kentucky and had a net gain of nearly 5% in membership since our last report. As of April 1, 1967, Kentuckians with extended benefits coverage totaled over 86,000 while major medical coverage was in excess of 22,000. A continuing and aggressive effort is being made to get people to reclassify to greater benefits.

A lengthy discussion and much interest have developed over the fee survey that Blue Shield is conducting at the request of the House of Delegates. Results of this survey will provide the Association with a mechanism to negotiate for usual and customary fees with the numerous contracts we now have with governmental agencies. In addition, major industry, representing a large market, is now demanding contracts that provide for the payment of usual and customary charges. Blue Shield must provide such plans to continue to be competitive in this market. Such "usual and customary" fees, participated in and created by physicians from the very outset, appears to be the most desirable procedure to us.

A glance into the very near future indicates that there is an increasing consumer demand for a large expansion of benefits under the voluntary prepayment system to cover such matters as prescription drugs and dental services. Proposals are being submitted to the Blue Shield Board and the Commissioner of Insurance to add two new benefits to all Blue Shield Certificates without an increase in subscribers dues.

1. Cover all children under a family membership from birth instead of the present 30 days of age.
2. Cover all mentally and/or physically handicapped children on family contracts for life.

Another matter receiving our attention was the remuneration of house physicians, and the Commission members agreed by consent with the KMA policy on this subject which is "that all funds generated in payment for professional services performed by physicians in training be maintained under professional physician control and that the disposition of these funds be left to local policy."

The record of the Advisory Commission reflects an upgrading of Blue Shield coverage for our citizenry and a friendly and close liaison between the profession and our Blue Shield Plan. Our goal is to continue and strengthen our role in these assignments.

For the invaluable assistance and support of the activities of this Commission, your chairman wishes to express his gratitude to the members of the Commission, the Board of Trustees, House of Delegates, and the staffs of Blue Shield and KMA.

Advisory Committee to Blue Cross

George W. Pedigo, M.D., Louisville, Chairman

Members of your Advisory Committee to Blue Cross met approximately once each month on a rotating basis to review questionable or controversial claims submitted by physicians that deal with the need and/or duration of hospital care. Annually, we have a meeting of the entire committee in conjunction with representatives from Blue Cross to discuss the work of the committee and to make constructive recommendations to Blue Cross.

During the past nineteen months (for the period ending in May, 1967,) the committee has reviewed 146 cases in thirteen meetings amounting to 5,440 hospital days. Of this amount, 1,708 days were disallowed, representing a savings of nearly $60,000. It is also interesting to note that local review committees have considered 231 cases during this same period, and disallowed 479 days for a savings of approximately $17,000.

Our committee consists of seventeen appointed physicians from across the state, and these individuals are to be congratulated for their diligence, dedication to duty, and faithfulness. While they reflect KMA's and Blue Cross's efforts to screen hospitalization to keep down unnecessary or prolonged hospital stay, their work also produces educational features for other Kentucky physicians.

Detailed records of this committee's work during the past Associational year are on file in the offices of KMA and Blue Cross.

Mental Health Committee

Logan Gragg, M.D., Lexington, Chairman

The Mental Health Committee met twice during the Associational year. To maintain close liaison with the Kentucky Department of Mental Health, the Committee invited the Mental Health Commissioner, Doctor Dale Farabee, to attend its meetings. Doctor Farabee gave the Committee details of his planning in both hospital and community programs.

The Committee took note of the KMA Study on Fragmentation of Health Services as this study related to mental health programs. It was the Committee's opinion that the existence of the Kentucky Department of Mental Health as a separate entity had been of great value in the development of the present mental health program in Kentucky. Members of this committee met with the KMA Committee to Study Health Services to discuss this opinion.

A representative of the Kentucky Academy of General Practice met with the Committee and, as a general need was expressed, we assisted in opening the way for better lines of professional communication between the Kentucky Psychiatric Association and the KAGP. As a result of the same discussion, the Committee formulated a recommendation to the effect that the KMA Journal periodically present a case discussion in psychiatry.

In view of the rapid growth of interest in development of regional mental health centers in Kentucky, the Committee recommended reaffirmation of KMA's support of these programs with the encouragement of physicians to be cognizant of and participate in these programs to preclude being displaced by nonprofessionals not having medicine as their primary interest.

The Committee transmitted digests of its meeting to all county society mental health chairmen.

Tuberculosis Committee

Adam Miller, M.D., Lexington, Chairman

The Tuberculosis Committee met at the KMA Headquarters Office on Thursday, April 27, 1967. The Committee's duties as approved by the Board of Trustees were noted as a guide to the purposes of the committee's activities. The Final Report of the 1966 House of Delegates was briefly reviewed, with the committee noting the action taken by the House on last year's recommendations.

The testing of school children for tuberculosis is considered by the members of this committee to be a very important part of the over-all program to reduce tuberculosis in Kentucky; and by consent, we reiterate our endorsement of testing of school children in Kentucky.

The apparent lack of cooperation which exists between various agencies which are involved with TB control in Kentucky is a matter of major concern to this committee. We are of the opinion that there must be more cooperation between the State Department of Health, the Kentucky Medical Association, the voluntary agencies, and the Kentucky Thoracic Society. It may be further pointed out that Kentucky is now second in the nation only to the state of Nevada in incidents of TB reported in 1966. After discussing in detail the TB program in Kentucky and all the agencies involved in carrying out this program, the TB Committee recommends to the House of Delegates the adoption of the following resolution:

"WHEREAS, according to preliminary figures just released by the National Communicable Disease Center in Atlanta, Georgia; Kentucky, with 1,344 new active cases of tuberculosis reported last year, had the second highest case rate in the entire continent of the United States, and

WHEREAS, Kentucky's rate of 42.2 cases per 100,000 population is nearly double the national average of 24.4 for the continental United States, and

WHEREAS, Kentucky's case rate is exceeded only by Nevada with a 50.4 case rate, and

WHEREAS, in 1965, Kentucky's case rate was the fourth highest in the United States, now therefore

BE IT RESOLVED that the Kentucky Medical Association urge the Kentucky State Department of Health to provide strong leadership in the coordination of the attack on tuberculosis in the state, using all available agencies, both governmental and voluntary in their efforts."

Our committee approves, encourages and recommends to the House of Delegates such activities on tuberculosis control as the Martin County project and the Campbell House Conference, and we point to these stellar projects to be followed in the future by all those who are interested in tuberculosis control in Kentucky.

We are deeply concerned by the lack of positive results on the TB eradication programs in Kentucky and invite the attention of all physicians to this problem. The encouragement of physicians and all cooperating agencies on the TB eradication program is imperative if we are to foster positive support for progress on this important project in Kentucky.

Cancer Coordinating Committee

Condict Moore, M.D., Louisville, Chairman

The Cancer Coordinating Committee met twice this Association year, on January 4, and June 6, 1967, and we were pleased to have representatives from the Kentucky Chapter, American Cancer Society and the State Department of Health in attendance at both sessions. Prime consideration at both of our meetings centered around the State Cervical Cancer Screening Program, the working plans for which were approved by the House of Delegates in September 1966.

At our first meeting we were concerned with how to increase participation in the program, noting that the two predominant problems were (1) transportation, communication and coordination out in the state and, (2) lack of communication with county medical societies. It was generally agreed that for the program to be successful it must have support from KMA, each county medical society, and the American Cancer Society.

During our second meeting we reviewed in detail the report (as of May 31, 1967) of the Cervical Cancer Screening Activities presented by representatives of the Department of Health. As a means of providing further information to members of the House of Delegates, a portion of the above mentioned progress report will be added as an addendum to this report.

We also clarified various types of participation of the sixty-three counties currently involved in the project and our committee members agreed upon a plan to explain the pros and cons of a true screening program in cancer of the cervix to selected county medical societies. Participation in this explanatory effort is to include representatives of the Kentucky Chapters of the American College of Surgeons, American College of Pathology, and American College of Radiology.

In other action, it was agreed that the present State Cancer Registry machinery should be on a minimal maintenance only, since legally it must be in existence.

Your chairman wishes to express his appreciation to the members of this committee and to our guests for their participation in and valuable contribution to the committee activities.

PRELIMINARY REPORT OF CERVICAL CANCER SCREENING ACTIVITIES AS OF MAY 31, 1967

Forms Received	3,951*
Nurses Trained	52
Total Counties Participating	63**
1) Counties in which screening is being conducted in connection with Family Planning or other program only	24
2) Counties in which screening has been instituted as regular county health department function only	24***
3) Counties in which program is being conducted through the local physician's offices only	9
4) Counties in which screening is being conducted both in the county health department and in local physicians offices	4
5) Counties conducting mass screening staffed by local physicians (Green—no indigency limitation, limited to those who have never had a Pap smear	2
Calloway—no limitations, 4th year of screening clinics)	
Biopsies Recommended	41
Follow-up Complete	31
Follow-up Pending	10
Biopsies Done	26
Cancer Diagnosed	15
Pathology Reports In	14
Cervical Cancer	11
Invasive	2
In-Situ	9
Vaginal Cancer	2
Endometrial Cancer	1

* A two to six-weeks lapse occurs between taking of the smear and receipt of a copy of the screenee's Epidemiological record at the Cancer Program Office.

** Also participating are London T. B. Hospital and Knox County E.O.C.

*** Fourteen of these counties are not yet using nurses to obtain smears. Several of these have nurses scheduled for training.

This report is prepared for a progress report to the Cancer Coordinating Committee and does not represent a complete evaluation of the program. A comprehensive report, including cost-analysis, will be prepared after the close of the fiscal year.

To obtain a representation of the population screened, a limited evalutation of 5 per cent of the received forms was done. Every twentieth form from each county, starting with number 5, was checked. This resulted in 202 forms being included in the survey, while if every twentieth form received in this office had been surveyed, the number of forms checked would have been 197. No particular significance is ascribed to this other than a slight preponderance in the per cent of early screenees included in the survey. Since a less complete form was used during the early months of the program, this makes a larger "unknown" category in those questions which were not included in the earlier screening form.

Screenees reporting they had ever received a "Pap" smear previously.	Yes	74
	No	128
Screenees reporting they had ever had abnormal vaginal bleeding.	Yes	28
	No	174
Screenees reporting their private physician suspected cancer.	Yes	5
	No	197
Screenees presently or previously using contraceptives	Unknown	65
	None	97
	"Pill"	30
	IUD	1
	Other	9

Public, Rural and Occupational Health Committee

Walter L. O'Nan, M. D., Henderson, Chairman

The Public, Rural and Occupational Health Committee has met twice this year, on December 14, 1966, and March 23, 1967. At our first meeting we discussed the new responsibilities of this committee since we had become a consolidation of the Public Health Committee, Rural Health Committee, and Industrial Medicine Committee of last year. We reported to the commission studying the reorganization of KMA that we felt there could be a better consolidation made in the future to separate some of the responsibilities now assigned to us.

Last year the Industrial Medicine Committee recommended that action be initiated for the establishment of an Employee Health Service unit for employees of the state. It has been reported to us that Reference Committee No. 4 (1966) did not recommend approval of this because it was felt this could be better handled by private physicians than by a state health service where they would be taking care of their own employees, and further it was pointed out that state employees comprise almost the entire practice of the physicians in Frankfort.

We wish to report that this was not the idea the committee had in mind last year and that there was a misunderstanding on the part of the members of the Reference Committee. The assumption that an Employee Health Service would take over total health care of these patients is in error as this is not the role of such a health service. An employee health service would not take over patient care but act as a coordinating and referring agency that works closely with both the patient and the physician. We are continuing our study of this subject and hope to report more to you at a later date.

Our committee is concerned with the inadequate training and supervision that people engaged in audiometric and visual-testing are receiving. We have made recommendations concerning such training and supervision and are awaiting with interest the comments of the Kentucky EEN&T Society concerning their feelings on this matter.

Other matters receiving the attention of the members of this committee during this past year include the following:

1. The Annual Governor's Occupational Health Conference. The theme for the conference this year was "The Function of Management in Occupational Health." In the first year (1965) this conference was self sustaining, while each sponsoring organization was assessed $8.00 in 1966 and $15.00 this year. Our committee members feel the procedures for conducting this conference in the future should be the same as past conferences but there should be no open end assessment of sponsoring organizations of which KMA is one. We further suggest the name of the conference be changed to Kentucky Occupational Health Conferences.

2. Immunization Week. This has been a promotional program of this committee for a number of years and was conducted during May 1-6, 1967. Special emphasis was placed on the encouragement of immunization against measles during our past campaign which we promoted through radio, television, newspaper and KMA communications media. We are most grateful for the cooperation of the Kentucky physicians in helping to make this program a success.

3. Community Health Week. We are also pleased to fulfill another responsibility and that is the annual promotion of Community Health Week which will be held this year during the period October 15-21. It is hoped that county medical societies will join with allied health groups to emphasize the local medical progress, available health facilities, and services, and the individual and cooperative roles played by members of the Community Health Team during this special week.

4. Rural Health. During past years there has been a Rural Health Conference sponsored by KMA and a number of other organizations with KMA carrying the largest load of responsibility and financial obligation. While there will be no conference this year, our committee is continuing its interest and activities to be of help to rural people without the conference.

5. Tobacco and Health. In view of the large amount of publicity and significant reports released by the U. S. Public Health Service, this committee has had under discussion the use of tobacco, cigarette smoking and health.

A resolution was unanimously passed to have cigarette advertising deleted from our Kentucky Journal and refuse cigarette manufacturers space at our Annual Meeting to distribute samples. This was ratified by the Council on Medical Services but was rejected by the Executive Committee of the Board of Trustees.

6. Venereal Disease. The rising venereal disease case rate has been discussed by this committee. In addition to the significant role of the physician in controlling venereal disease, we believe that all hospitals should emphasize and encourage the giving of VDRL and chest x-ray as routine laboratory tests on admission to hospitals.

Most KMA members are now aware that the KMA Diabetes Detection and Education Program has been discontinued at the state level since the Department of Health is conducting a similar program on a year-round basis. We encourage physicians in Kentucky to do diabetes tests either under the state program or the American Diabetes Association Program during the regular Diabetes Detection Week.

Your chairman wishes to thank all the members of this committee for their interest and participation in the many diverse facets of concern which fell under the responsibility of this committee.

Dental-Nurse-Pharmacy and Related Groups Committee

A. Evan Overstreet, M.D., Louisville, Chairman

Our committee held one meeting during this past Associational year, on February 8, 1967. Following a review of the duties of this committee, we entered into a general discussion of relationships between the medical profession and allied and related groups. Consideration was given to physicians-optometrists relationships and a recommendation concerning this matter was forwarded to the Board of Trustees.

As a result of our report to the House of Delegates last year, it became KMA policy that physicians should be discouraged from leaving prescription pads where they are available to patients or unauthorized persons to use for illicit drug procurement and that precaution should be taken to eliminate such an opportunity. As a courtesy, some drug houses preprint narcotic numbers on prescription pads for physicians' use. Upon our recommendation this year, the Board of Trustees established that it be KMA policy that physicians do not use or have any blank prescription pads with narcotic numbers preprinted thereon.

Other matters receiving attention of this committee were nursing education, joint policy statements previously agreed upon by the Kentucky Nurses Association and KMA and reports and resolutions of the AMA pertinent to this committee's interest.

COUNCIL ON MEDICAL SERVICES
John A. Bishop, M.D., Jeffersontown
Ellis A. Fuller, M.D., Louisville
Logan Gragg, Jr., M.D., Lexington
Walter L. O'Nan, M.D., Henderson
A. Evan Overstreet, M.D., Louisville
Harold J. Schupbach, M.D., Owensboro
George W. Pedigo, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 4

The first item considered by Reference Committee No. 4 was Advisory Commission to Blue Shield. This included the reports of the Blue Shield and Blue Cross

Advisory Committees and the Mental Health Committee. It is recommended on page 8, paragraph 2 of the Report that the Tuberculosis Commission be inserted following the word Association occurring in the second sentence.

It is also recommended that the statistical information included in the Cancer Coordinating Committee Report be compiled with the statistical information from the Kentucky Academy of General Practice cancer screening committee so that a more complete picture of cancer screening in Kentucky be obtained.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Report of the Council on Communications and Public Service

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*
2. *Reports of the committees of this council with the council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Communications and Public Service called two meetings during the Associational year, on December 7, 1966, and June 29, 1967.

One matter discussed at our meetings related to the Ad Hoc Committee to Study the Reorganization of KMA. The general purpose of this committee and its reorganizational study was well received by the Council members.

One of the pertinent topics discussed at length was health careers, and it was felt that this was a very important aspect of the work of this council. We were indeed fortunate to have Mrs. Hoyt D. Gardner, chairman of the Health Careers Committee of the Woman's Auxiliary, at one of our meetings. She gave us a very excellent presentation upon the general principles and guidelines relating to health careers, and our council recommended to the Board of Trustees that a Health Careers Committee be formed within our organizational structure. This recommendation was approved.

There have been two orientation programs presented during this Associational year, and these programs continue to be well received. The format is being changed slightly for the fifth course, which will be presented Monday, September 25, just prior to the opening of our Annual Meeting. We want to express our gratitude to those individuals who appear as speakers on the orientation program.

During April, we presented two exhibits, one on "Seven Paths to Fitness" and one on "Medical Careers" at the annual meeting of the Kentucky Education Association. These were enthusiastically received, and credit should be given to O. B. Murphy, M.D., chairman of the School Health Committee, for his unceasing efforts to promote school health. We recommend that exhibiting at the KEA meeting be continued and wish to point out that it is imperative that someone as aggressively interested in these exhibits as Doctor Murphy should be involved in their presentation.

It is our recommendation that at the 1968 KEA meeting two exhibits again be presented, one on highway safety and the other on school health.

The Council has continued its policy of providing speakers to lay audiences on an informal basis and has been authorized to establish a formal speakers bureau should the need arise.

We reviewed a program entitled "Teenage Alert" now being conducted in Ft. Lauderdale, Florida, which deals with the teaching to teenagers the dangers of narcotics, alcoholism, clandestine sexual behavior, etc.

Our council members approve the "Teenage Alert" project for the education of teenagers and recommend that this matter be referred to the School Health Committee.

The following final reports of the committees serving under this council were reviewed and are submitted with Council action:

Disaster Medical Care Committee

William T. Rumage, Jr., M.D., Louisville, Chairman

The Disaster Medical Care Committee of the Kentucky Medical Association held several meetings during the past year. The Chairman is grateful to all the members of the committee and to the staff of the Association for their efforts.

In addition to the members of the committee, guests from organizations interested in Disaster Medical Care were invited to participate in the discussions of the committee. Representatives of the Kentucky Health Department, the United States Public Health Service, University of Louisville, University of Kentucky, American Red Cross, the Kentucky Pharmaceutical Association, the Kentucky Hospital Association, the Kentucky Dental Association, and the Kentucky Nurses Association all participated.

The following items were considered during the past year:

1. Further steps were taken to appropriately identify hospitals with acceptable emergency room facilities. The eventual identification of these facilities should be accomplished in the near future.

2. The National Highway Safety Act Standards concerning emergency medical services and the programs on accidental death disability of the National Research Council were reviewed, and several members of the committee worked on projects related to these standards.

Doctor James C. Drye has developed a program on emergency communications for the state of Kentucky, and it is hoped that future committees will be able to implement this report.

Doctor Charles Hornaday is reviewing available information on the transportation of the sick and injured and will have recommendations for future committee action.

3. The committee is concerned that no action has been taken for the registration of practicing physicians in the state of Kentucky as was recommended by the House of Delegates at the last Annual Meeting.

4. The facilities in the Kentucky Medical Association Headquarters were made available for a fully stocked fallout shelter. These facilities may be incorporated in a state-wide communications network in the future.

5. An article was prepared and published in the KMA Journal on the need for a doctor's emergency medical bag. Suggested contents were listed.

6. A conference sponsored by the Kentucky Medical Association, the Kentucky Hospital Association, and the Trauma Committee of the College of Surgeons was held on the problems of the emergency room. This conference was very well attended; and

as a result of the conference, emergency rooms across Kentucky should be surveyed.

7. Reports were received about the relocation of the packaged disaster hospitals nearer metropolitan areas. Reports were received about the increase in the number of individuals trained in medical self help. During the fiscal year ending June 30, 1966, there were 62,674 individuals trained in Kentucky making a total of over 150,000 that have been trained under the program to date.

8. The Emergency Resources Plan for the Commonwealth of Kentucky has apparently still not been approved by the Office of Emergency Planning.

9. Reports were received on Medical Education for National Defense from the University of Louisville.

10. Reports were received about the community disaster exercise held in Lexington.

11. The committee and staff participated in the United States Civil Defense Council Meeting held in Louisville.

12. The Chairman represented the Kentucky Medical Association at the AMA meeting on emergency medical services.

13. Emergency medical services are now receiving the increased attention which they have deserved. The Kentucky Medical Association should maintain an active committee with appropriate assistance from the staff and financial support to represent the membership of the Association in the development of programs in the near future. Many of these programs are being designed by the Federal Government with little understanding of the problems which exist in smaller communities and rural areas.

School Health Committee

O. B. Murphy, M.D., Lexington, Chairman

The School Health Committee met on February 1 and June 8, 1967, and we have directed our efforts toward improving the health of our school-age children with particular emphasis on physical education.

Again this year, we requested that each county medical society appoint a school health chairman. In each county where such a chairman was appointed, we informed the superintendents of the city and county school districts concerned of the name of this chairman and stated that he would be the school health advisor for that district.

We were pleased to have Fred Hein, Ph.D., Director of the AMA Department of Health Education, to appear before physicians interested in school health at the 1966 KMA Annual Meeting. At our request, Doctor Hein also accepted an invitation to appear on the program of the Kentucky Education Association Annual Meeting in April of this year. KMA had two exhibits at this meeting, one on "Seven Paths to Fitness" and the other on "Medical Careers." Your chairman had the privilege of helping to staff these exhibits during each day of the meeting and was gratified with the response of those attending the meeting and visiting the exhibits.

Another matter of interest to your committee this year has been the incidence of athletic injuries and insurance coverage in our school system. We have conducted a statistical survey of injuries, schools that have insurance coverage, etc.; and we are continuing our study in this area. We have also discussed and hope to propose standards for elementary, junior, and senior high school athletic programs.

A representative of the State Department of Health attended our second meeting and reported on the Health Department's participation in school health to include the types of services provided. As a further means of liaison, we also had a report from the Kentucky Chapter, American Academy of Pediatrics, on their current projects and planning in the school health field.

As a means of keeping abreast of programs being initiated at the national level, the committee is being represented at a national meeting on school health in Atlantic City during June of this year. Your chairman has also been appointed to the Kentucky State Department of Education's "Elementary Physical Education Guide Committee" which should provide further liaison and cooperation with school health programs in Kentucky.

While your chairman has been disappointed at the attendance of our meetings this year, we do wish to express appreciation to those committee members and others who have demonstrated interest in and provided assistance to the committee during the past year.

KMA Highway Safety Committee

William K. Keller, M.D., Louisville, Chairman

The Highway Safety Committee held its meeting on November 30, 1966, during this past Associational Year, and we were pleased to have as our guests Colonel James E. Bassett, Director, Kentucky State Police; Colonel Thomas R. Holsclaw, Chief, Jefferson County Police; Mr. Malcolm Patterson, Director of Public Affairs, Kentucky Department of Public Safety; and Mr. Don Sullivan, Director of the Division of Licensing, Kentucky Department of Public Safety.

Through this committee, the Kentucky Medical Association is sponsoring another three-year Kentucky Automotive Crash Injury Research Program in cooperation with Cornell University. This new study, the second to be conducted in our state, began on January 1, 1967, in 18 counties, and the program will change its study areas throughout the state each six months over a three-year period. It involves the study of injuries incurred in late model automobiles. The members of this committee would like to express their profound appreciation to Kentucky physicians for their outstanding cooperation in completing the report forms necessary to conduct this study.

Another project initiated by this committee a few years ago and still very much in existence is the Kentucky Driver Limitation Program, whereby physical examination of certain vehicle operators is mandatory. KMA members are to be especially commended for their participation in this program as the complete reports being rendered have been a basic factor in its success. We are most hopeful that a planned follow-up study will be made prior to the KMA Annual Meeting, which will help us determine the effectiveness of the program.

Another function of this committee is the awarding of the KMA Automotive Safety Award to those organizations achieving the installation of seat belts in all of their members' vehicles. Your chairman took great pleasure during our meeting in presenting the 9th KMA Automotive Safety Award to Colonel James E. Bassett, who accepted on behalf of the Kentucky State Police.

The Executive Committee has approved a recommendation made by our committee that the KMA support the principle of the Implied Consent Law. Under the principle of the Implied Consent Law, a person would, by signing his driver's license application, be giving consent for submitting to a blood alcohol test in the event he is subsequently apprehended under a charge involving drunkenness. While this recommendation supports the principle of the Implied Consent Law, actual support of such a law would depend upon the wording of the law as finally drafted.

With the Kentucky highway death toll increasing at a rate that indicates a new yearly death record almost every year, our committee members feel that interest and support should be placed behind any further action that may be made for increasing highway safety. Our committee has recognized that the driver point system is a positive step toward increasing safety on Kentucky highways. We do note, however, that it has definite limitations where there is reluctance on the part of enforcement officials to use the point system. This has been evident in some cases because of the social and economical hardships passed on to the individual and his family.

Significant new federal legislation on automotive safety was enacted during the last session of the United States Congress. The Traffic Safety Act of 1966, PL 89-563, has, as one of its objectives, a safer automobile through mechanical improvements. Further requirements of this law establish a national drivers registry containing the names of all drivers who have had a drivers license revoked or suspended. Under the Highway Safety Act, PL 89-564, there are stipulations whereby federal highway funds are related to highway safety standards. It is the consensus of our committee members that these new laws will have a positive effect on highway safety.

Your Chairman wishes to express his personal appreciation to members of this committee, the Department of Public Safety, and other individuals and groups who have contributed and supported the activities of this committee during the past year.

Senior Day Committee

Hoyt D. Gardner, M.D., Louisville, Chairman

Our annual program at the University of Louisville School of Medicine were held on March 20, 1967, in the Medical Arts Building with the Jefferson County Medical Society as co-host. Our speaker of the evening was Doctor Thomas Haggai. The afternoon presentations by panelists followed the traditional pattern.

Our program in Lexington, co-sponsored with the Fayette County Medical Society, was on Tuesday, April 11, 1967. Doctor Milford Rouse, Dallas, Texas, President-Elect of the American Medical Association, was the evening speaker. The same program was given in the afternoon as for the University of Louisville.

The attendance by the students at both of the schools was very good and comments about the programs afterwards also indicated their value to them. It was the consensus of both groups, without question, that these were beneficial and should be continued.

It was felt that the planning of the programs in the early fall, as has been customary, with the similar format be continued. It was felt this is a good effort by our state Association and one that is well received by the recipients, and its rewards will be felt through the years. No changes in the outlines of the presentation or basic changes in the structure are recommended.

This type of informational program to medical students and the compulsory orientation seminar for new members has been well received and accepted by them. Because one of organized medicine's great problems is communication, one cannot keep from feeling that a similar type of informational program for active members should be done on a regular basis with it being a requirement for members to attend one such program at least once every five years. This would mean that at least once each five years, every member would be brought up to date about medicine's organizational programs. The time possibly could be scheduled at the regular annual meeting, so as not to require an additional meeting.

Committee On Medicine And Religion

R. Burke Casper, M.D., Louisville, Chairman

The Committee on Medicine and Religion has continued during this past year to pursue its assignment of promoting activities concerning Medicine and Religion within the state Association and to the County Medical Societies. Although attendance of committee members has been disappointing, we have held two meetings since our last report, on March 2 and May 3, 1967. The fifteen KMA Trustee District Chairmen were invited to both meetings, and we were also pleased at our second meeting to have a number of ministers, both pastors and hospital chaplains, as our special guests.

Mr. Arne Larson, Assistant Director of the AMA Department of Medicine and Religion, was in attendance at our March 2 meeting and offered the resources of the AMA Department to us in promoting physician-clergy relationships to bring about a better understanding between these two professions. We are most appreciative to Mr. Larson for his assistance to us, not only in the past years, but since the first appointment of this committee.

Reports solicited from the District Chairmen indicate that the bringing together of the two professions (medicine and clergy) for coordinated efforts in patient treatment has proved to be a most interesting, rewarding, and stimulating experience. The AMA film "The One Who Heals" was shown at both of our meetings. This film superbly tells the story of the benefits derived from closely coordinated efforts of physicians and ministers and is highly recommended for showings at County Medical Society meetings.

The Committee members were honored to have had David A. Steere, Th.D., Professor of Pastorial Theology and Director of Field Education at the Louisville Presbyterian Theological Seminary, appear as guest speaker at our Second Annual Breakfast Meeting during the KMA Annual Session last year. Doctor Steere, speaking on "Barriers to Inter-Professional Cooperation" so favorably impressed us with his remarks that they were printed in the May issue of the Journal of KMA at our request. If you have not read this article, we urge you to do so at an early opportunity. Our Third Annual Breakfast Meeting will be held this year on Wednesday morning, September 27, at 7:00 A.M. in the Kentucky Hotel.

One of the committee's projects during the past three years has been to tape record interviews with KMA members on physician-clergy relations. These tapes were edited, circulated to our committee membership for information and are available for loan to those interested in studying and promoting clergy-physician activities.

A highlight of this year's committee activities was our session with six Kentucky church pastors and hospital chaplains. Throughout our discussion, there was general agreement that better understanding may and should be promoted between our professions. A development of common interest between physicians and ministers to better understand and know each other would surely result in better patient care, i.e. "treating the whole man." Having coffee together in hospital lounges and sharing reading material on a subject of mutual interest are suggested as two of numerous avenues for developing friendship and understanding.

Your chairman feels that a harmonious relationship between the professions of medicine and religion plays a significant role in patient care and suggests that medical education at the undergraduate level affords an opportunity to acquaint the developing physician with the role of the minister in patient care and treatment.

Advisory Committee To Woman's Auxiliary

George W. Pedigo, Jr. M.D., Louisville, Chairman

The Advisory Committee to the Woman's Auxiliary of the Kentucky Medical Association was not requested by the Auxiliary to have a meeting, and our advice was not sought during the past year.

University Of Louisville Chapter Of Student AMA

Hoyt D. Gardner, M. D.,
Louisville, KMA Representative

They have conducted the usual annual business with monthly meetings. They have done it in a most commendable and good fashion. Also, there has been additional liaison and cooperation between our local chapter and the WASAMA Auxiliary. There have been mutual meetings with the Kentucky chapter, and the liaison between the two schools continues to be

excellent. Ted Buckner served as this year's president and did a good job in this capacity.

They attended the annual SAMA meeting held in Chicago this year and were helped in this regard by the usual contribution from KMA. Four members of the local chapter were in attendance.

Again, it has been a most comforting and rewarding experience working with this young blood of our profession. They exemplify in every way, the high ideals of the profession and have carried out their activities and duties in a responsible and professional and ethical manner. It is with these kinds of young men that we can see that the future of medicine continues to be bright and will continue to grow.

COUNCIL ON COMMUNICATIONS
AND PUBLIC SERVICE
R. Burke Casper, M.D., Louisville
Donald E. Edger, M.D., Lexington
Irving F. Kanner, M.D., Lexington
William K. Keller, M.D., Louisville
Willis P. McKee, M.D., Shelbyville
O. B. Murphy, M.D., Lexington
N. Lewis Bosworth, M.D., Lexington,
Chairman

Recommendations, Reference Committee No. 4

The Committee wishes to commend the Disaster Medical Care Committee for their diligence and activity in this area.

It is recommended that paragraph 3, page 4 of this report be deleted as the action has been accomplished.

The Committee wishes to express its concern and interest in the School Health Committee Report of the statistical survey of athletic injuries in our schools. The question of athletic insurance coverage in our schools is a matter that should receive our continuing attention.

We note with pleasure the activities of the Committee on Medicine and Religion and encourage the continuing of promotion of physician-clergyman relationship in the state.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Report Of The Board Of Directors Of Kentucky Physicians Mutual, Inc.

It is a privilege, as Chairman of the Board of Directors of Kentucky Physicians Mutual, to bring this annual report on Blue Shield to you . . . the House of Delegates of the Kentucky Medical Association. This is our 18th year of service to the people and doctors of Kentucky. We will pay, this year, over $10,750,000 to doctors for services to our members. Our Blue Shield Plan is financially sound and continues to grow, as indicated by the following figures.

We had, as of June 30, 1967, 934,627 members, which is a net gain of 5.02% in the preceding twelve months. In addition, over 116,000 people enrolled in Extended Benefits or Major Medical, which is a net gain of 48%. During the past twelve months, 875 additional companies enrolled their employees in Blue Shield, making in excess of 8900 companies and organizations in Kentucky voluntarily offering this vital protection to their employees and dependents. Eighteen hundred of these companies provide Extended Benefits or Major Medical to their members.

Forty-eight thousand, one hundred ninety-five members over 65 years of age are now enrolled in our "Blue Cross-Blue Shield 65" program to fill voids in Medicare. We are pleased that during the year we were able to increase the protection for these members by reducing the deductible from $100 to $50. Other changes and improvements will be made now that we have one year's experience and since Congress is altering Medicare protection. The increased benefits will attempt to help meet the additional needs of members for this age group and fill voids in their protection.

Kentucky Physicians Mutual is sound financially and now has in reserves $6.94 per member, for a total of $6,466,559.56, which is deemed adequate.

At the request of this House of Delegates in September, 1966 (when Resolution A was passed), Blue Shield was asked to conduct a survey of physicians' charges in cooperation with the Kentucky Medical Association and the Department of Health for the purpose of determining usual and customary fee data. It was anticipated that the cost of the study would be shared by Blue Shield and the Kentucky Department of Health. Circumstances that developed prompted your Executive Committee and Board of Trustees to request Blue Shield to do the study with the Kentucky Medical Association and to assume the full cost. The survey was completed with the guidance and advice of the Kentucky Medical Association Statewide Fee Survey Committee. Sixty-six percent of the practicing physicians in Kentucky responded to the survey. Resolution A provided that the results of the study would be confidential and would be released only at the discretion of the KMA Board of Trustees. The Board of Trustees requested the release of the results for x-ray and laboratory procedures, but not to include individual physicians' names or profiles. These results were delivered to the Kentucky Medical Association central office so that they might use them in working with the Department of Health and the Title XIX Program. No statistics have been released, nor will any be released, without the written authorization from your Board of Trustees.

Kentucky is more and more becoming a branch office, branch plant state. More companies are merging every year and subsidiary plants and offices are being opened in Kentucky all the time. Decisions made in New York, Nashville, Atlanta, Pittsburgh, Cleveland, Detroit, and numerous other areas vitally affect the protection for thousands of Kentuckians. More and more companies are demanding uniform benefits for their employees and their dependents. The voluntary system is being faced every month with additional demands for full payment of benefits. Unless these demands are met, the companies as well as the unions will turn more and more to government. Effective August 1, 1967, the steel companies all over America bought for their employees and dependents a usual and customary contract. Over 24,616 of these members are in Kentucky. These companies who are willing to purchase usual and customary or prevailing fees for protection for their employees and dependents are demonstrating a tremendous vote of confidence in doctors, the voluntary system, and are helping to maintain the free choice of physicians, by agreeing to pay adequate dues so as to pay the doctor his own regular charges for covered services rendered.

Effective August 1, Blue Shield also extended protection, at no increase in rates, to children from birth, and to mentally retarded and physically handicapped dependents, regardless of age, who are enrolled on family contracts.

We are now also in the process of contacting all enrolled firms in Kentucky, and non-group, direct-pay, and Farm Bureau members, attempting to get all those who do not carry maximum protection to upgrade their benefits. This means, of course, they will have to be persuaded to pay higher dues.

Kentucky Blue Shield continues to operate with one of the lowest overhead costs among the 74 Plans in America. In Plans of comparable size, from 500,000 to 1,000,000 members, out of 17 in America, Kentucky is among the low four in overhead cost.

Early in June, our chief executive officer, Mr. D. Lane Tynes, announced his retirement as of July 1. Mr. J. Ed McConnell was elected president, as his successor, with Mr. Don Giffen as executive vice president. Both men have been with Blue Shield since it originated.

The voluntary prepayment system is healthy and growing, in spite of the threats from every side. Working together with the medical profession, industry, and other segments of our community, with a sincere desire to do what is beneficial to all concerned, we should continue to help strengthen the voluntary system, the private practice of medicine, and to help more and more people budget in advance so that they may be in a better position to provide adequate health care for themselves and their families, and at the same time maintain the free choice of their doctor and hospital.

We wish to extend to the members of the medical profession and to the staff of the Kentucky Medical Association our sincere thanks for their cooperation and contribution in helping make this another successful year.

Robert W. Robertson, M.D.
Chairman, Board of Directors
Kentucky Physicians Mutual

Recommendations, Reference Committee No. 4

We are pleased to observe the continuing growth and improvement in coverage of Blue Shield in Kentucky. We would like to extend the congratulations of the Association on the recent promotions of Mr. J. Ed McConnell and Mr. Don Giffen.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Report Of The Ad Hoc Study Committee For Improved Community Health

The Study Committee for Improved Community Health was established to implement Resolution D as amended by the House of Delegates in September, 1966. This Resolution called for the following:

1. That KMA establish leadership in forward looking and imaginative planning for tomorrow's community medicine;

2. The medical profession strive to identify with total medical care problems of society, to study and understand such problems and assume leadership in formulation (with others) of solutions to these problems, recognizing the valid interest of both the public and the profession;

3. KMA should provide a way for the maximum participation of its members, maximum flexibility in responding to the immediate and future problems in scientific, social and economic aspects of medical care, and encourage experimentation and innovations in medical care patterns;

4. Data and background information from throughout the state should be coordinated and programmed by the leadership from KMA;

5. This committee shall conduct an on-going study in all the areas above, including medical needs of citizens at a community level;

6. At the meeting of the Board of Trustees of KMA on December 7, 1966, it was decided this committee should at this time limit its work to a cost and feasibility study on this problem.

The Committee feels that to carry out the Resolution it will be necessary to encourage county societies to establish committees for the improvement of community health. Membership on such committees should include lay people as well as physicians. Such committees shall study local health problems and formulate solutions to them.

The *ad hoc* committee or its successors should coordinate the work of the county committee noted above and should assist in furnishing information to those committees of the way similar communities with similar problems have solved them.

The committee met five times and used for consultation Kurt Deuschle, M.D., Ann Pressman, M.D., Donald Hochstrasser, M.D., Eugene B. Gallagher, Ph.D., from the University of Kentucky Medical Center; and G. Dudley Nelson, M.D., from the University of Louisville School of Medicine, and particularly notes the cooperation of the Department of Community Medicine at the University of Kentucky Medical Center in its assistance to the committee. The committee recommends the following motion be accepted by the House of Delegates in order to accomplish the purposes of this committee:

> That we utilize the services and information that the Department of Community Medicine of the University of Kentucky can provide. We shall initially study a maximum of four pre-selected communities that would be agreeable to the Department and to this committee. The information provided this committee on these four communities shall be reviewed by this committee or its successor, and at that time steps be taken to implement the establishment of community committees of physicians and lay people.

Inasmuch as the Department of Community Medicine clerks (senior medical students) will leave on August 14 to start their work in a number of counties in the state, it was felt that of the counties which these students were to survey that Hopkins, Adair, Bourbon, and Clay counties would represent the widest variation of the counties these students will cover; therefore these four were selected.

The committee feels this is entirely feasible and can accomplish the purposes of Resolution D. During the first phase there will be no expense to KMA, but it is estimated that when community committees as envisioned above are established, there will be an average cost to KMA of $220 per committee for staff time and travel to help the communities in establishing such committees.

It is the feeling of this committee that it would be wise for KMA to consider the first studies as pilot studies to allow for improvement in methodology for the improvement of future such programs. This committee feels this work is an important function of KMA and should be continued, and therefore further recommends that KMA continue an ad hoc committee on the study of the improvement of community health to give proper guidance to this work.

The Committee wishes to thank the KMA Staff, Mr. Sanford, Mr. Cox and Mrs. Murphy who have been most cooperative in the accomplishment of this committee's job.

AD HOC STUDY COMMITTEE FOR
IMPROVED COMMUNITY HEALTH
Walter I. Hume, Jr., M. D., Louisville
Nicholas J. Pisacano, M. D., Lexington
Fred C. Rainey, M. D., Elizabethtown
Russell E. Teague, M. D., Frankfort
Irving F. Kanner, M. D., Lexington, Chairman

Recommendations, Reference Committee No. 4

The activities of this committee and the progress toward implementation of Resolution D of 1966 were discussed in considerable detail. It is thought important that the information that may arise from the surveys of various communities should be made continuously available to KMA and its constituent medical societies and that some provision should be made for the storage of such information.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded and carried.)

Resolution G

Cambell-Kenton County Medical Society

WHEREAS, quality medical care can only be assured by maintaining the fundamental principles of the patient-physician relationship free from the influence of third parties, and

WHEREAS this is embodied in the principles of medical ethics of the American Medical Association,

Section VI, which reads "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgement and skill or tend to cause a deterioration of the quality of medical care," and

WHEREAS this is embodied in the principles of individual responsibility wherein the physician is responsible to the patient for all aspects of rendering medical care to the best of his ability; and the obtaining and providing for the payment of medical care are the primary responsibilities of the individual citizen, and

WHEREAS the acceptance of benefits from a fiscal intermediary has posed in the past, and will continue to pose, a distinct threat to this patient-physician relationship and can result in deterioration of quality medical care, and

WHEREAS the attending physician's statement of individual responsibilities is reasonable and adequate for reports of medical services to patients for reimbursements and serves as a "direct billing" mechanism, thus eliminating all third party interference in the "Doctor-Patient" relationship;

NOW THEREFORE BE IT RESOLVED THAT the House of Delegates of the Kentucky Medical Association endorses and approves the ethics and the principles of Individual Responsibility in the distribution of medical services by physicians; and

BE IT FURTHER RESOLVED THAT the principles of individual responsibility are well sustained by an adequate statement of report by the attending physician, recognized as an ethical means for use by those physicians who voluntarily desire and decide to use it; and

BE IT FURTHER RESOLVED THAT all members of the Kentucky Medical Association be informed by the Board of Trustees of the Kentucky Medical Association of this action with supporting information in order that physicians may voluntarily preserve an ethical patient-physician relationship; and

BE IT FURTHER RESOLVED THAT the Kentucky Medical Association House of Delegates endorses the principle of direct reimbursement of the patient for the reasonable and customary fee for physician services by any third party—whether private, state or federal upon presentation by the patient of the physician's report on a standardized form; and

BE IT FURTHER RESOLVED THAT the House of Delegates instruct the Board of Trustees to make necessary arrangements and to implement the principles of the Individual Responsibility Plan regarding all third party participants effective as of this date, with the understanding that participation in such a program is entirely voluntary.

Recommendations, Reference Committee No. 4

It was the feeling of the Committee that much of this Resolution duplicated previous policy statements of the KMA and AMA. The Committee approves in principle all the elements of this Resolution.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

Resolution P

Tuberculosis Committee of the KMA

WHEREAS, in 1966 Kentucky had the second highest case rate in the nation, and

WHEREAS, tuberculosis is the most serious communicable disease in Kentucky, infecting more than 1,200 new persons each year and killing approximately 200 persons each year, and

WHEREAS, tuberculosis can be eventually eliminated from Kentucky, if detected early and properly managed, and

WHEREAS, one-fourth to one-third of all Kentuckians harbor tubercle bacilli in their bodies, and

WHEREAS, there are many Kentuckians who should now be under medical care for clinical tuberculosis, and

WHEREAS, tuberculosis still causes more disability and death among Kentuckians than all other infectious diseases combined; therefore be it

RESOLVED, by the Delegates of the Kentucky Medical Association that we instruct the appropriate committee to compose, in conjunction with the Kentucky TB and Respiratory Disease Association, health messages relating to the prevention, diagnosis and treatment of tuberculosis for use on outdoor billboards throughout the state of Kentucky.

Recommendations, Reference Committee No. 4

The Committee was informed that the expense of the erection of the billboards referred hereinto was not to be assumed by the KMA.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Mr. Speaker, I move the adoption of the report as a whole.

(Motion was seconded and carried.)

The Chairman wishes to thank the members of the Reference Committee who contributed so unselfishly of their time and knowledge.

REFERENCE COMMITTEE NO. 4
W. Fielding Rubel, M.D., Louisville
Chairman
W. E. Becknell, M.D., Manchester
Kenneth M. Eblen, M.D., Henderson
Robert Robbins, M.D., Greenville
James B. Tolliver, M.D., Whitesburg

REFERENCE COMMITTEE NO. 5

Andrew M. Moore, M.D., Chairman

Report on Governmental Medical Services

Reference Committee No. 5 considered the following reports:

16. Report of the Council on Governmental Medical Services
Supplemental Report B, Board of Trustees
Supplemental Report C, Board of Trustees
Resolution F—Medicaid (Fayette County)
Resolution I—Negotiations of Governmental Contracts (Fayette County)
Resolution N—Fiscal Agent for Title XIX (Fayette County)
24. Report of the Advisory Committee to Selective Service

Report Of The Council On Governmental Medical Services

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the bylaws, which reads in part:

". . .Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Governmental Medical Services is presented in the following order:

1. *Actions and recommendations by the council which it undertook on its own initiative.*

2. *Reports of the committees of this council with the council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Governmental Medical Services met three times during the Associational year, on November 9, 1966; March 29, 1967; and June 14, 1967. All of the committees, except one, serving under the council have met at least once during the year and have made an excellent contribution to the smooth functioning of this new council. Much help has been obtained from Mr. James Fleming, Secretary of Committees on Welfare Service of AMA and his reports, and also from Doctor Howard W. Doan, Assistant to the Director, Division of Socio-Economic Activities of the American Medical Association.

From the multiplicity of reports and regulations received by most Kentucky physicians regarding Governmental Medical Programs this year, it is apparent that the first year of increased government participation in medicine has been a difficult one. We have tried to live with Medicare, we have recommended a type of Medicaid, and we have looked with some questions at O.E.O. programs, the new Governmental Contract Programs, Air and Water Pollution Control recommendations and multiple grants from the federal government to states for various research and control medical studies. These are so multitudinous that it leaves the council quite fatigued and at a loss to know just how to report to the KMA on its evaluation of the various intrusions of non-medical, government-oriented personnel into medical practice today. Too often the programs that look good on the surface are found to be more and more interfering with our long cherished doctor-patient relationship, bringing little good to the patient or the physician.

Early in the year, it was apparent that there was overlapping of duties of various councils of KMA, and it was recommended by the first session of this council to the Hoover Commission that:

"WHEREAS, the functions of the Councils on (1) Medical Education and Hospitals, (2) Legislative Activities, and (3) Governmental Medical Services are to some extent overlapping and promise to become more so in the future; and

WHEREAS, each reports independently to the KMA House of Delegates at the present time;

THEREFORE, BE IT RESOLVED, that this Council recommends to the Commission to restudy the reorganization of KMA, that it consider the desirability of regrouping these three councils under a single coordinated authority, which would report for all three to the Board of Trustees and to the House of Delegates."

Efforts were made through several channels to find some method of direct billing by Kentucky physicians of all patients on governmental medical programs, but all of these were stymied at the federal level, and it was learned that any answer must come from future federal legislation.

The matter of compensation from government sources to clinical laboratories was discussed at each council meeting and at the KMA Interim Meeting of April 19, 1967. The council informed the KMA Board of Trustees that it was opposed to compensation from government sources for services provided by laboratories not under the direct supervision of a licensed physician. Later, proposed regulations of such laboratories by Health, Education and Welfare were reviewed and reported at the Interim Meeting and the Board of Trustees suggested that this Association encourage the State Department of Health to set up a regular checking laboratory service for the purpose of certifying or licensing of clinical laboratories. At the last council meeting, the Kentucky Society of Clinical Pathologists, in cooperation with the Kentucky State Society of Medical Technologists was encouraged to draw up legislation to recommend to the Legislative Council for such licensing at state rather than federal level.

This matter was discussed again when the Council reported to the Board of Trustees on August 2, 1967. A letter from the Campbell-Kenton County Medical Society to the Board of Trustees was presented, which read as follows:

"Gentlemen:

At the General Meeting of the Campbell-Kenton Medical Society on May 4, 1967, a resolution was presented and accepted that the Society be on record approving licensure status be established for the independent laboratories located in Kentucky.

The above would aid in establishing adequate criteria to assure that only qualified facilities would be available. Also, it would halt the rather rapid federal intervention into what should be the business of the state. The type of licensing procedure has been carried out in other states quite effectively.

The members of the Society would appreciate this being given full consideration in the very near future.

Very truly yours,
Donald Janney, M.D., President"

The above being the same request presented by this Council, the Board of Trustees recommended that the Legislative Council proceed with drawing up such proposed legislation.

A portion of Resolution "C" from the 1966 KMA House of Delegates was the responsibility of this Council in that it encouraged the start of a legislative program authorizing the state to contract with any private agency, business firm or separate corporation in order to administer the medical care provision in any and all parts of Title XIX. This resolution has since been studied by the Board of Trustees and their recommendations will be presented before the 1967 House of Delegates.

Following the last meeting of the Council, the American Medical Association at the June, 1967, Annual Meeting, considered two resolutions (16 and 108) pertaining to "Control over the Practice of Medicine" that the Council brings to your attention. The resolutions asked that AMA undertake an analysis to determine if, in implementing Public Law 89-97 (Medicare), agencies of the government have violated the provisions of the law, and more specifically Section 1801.

Section 1801 of P.L. 89-97 states, "Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

The reference committee to which these resolutions were assigned agreed that a careful examination for evidence of violation in the implementation of the law should be undertaken. It was added that the cooperation of component medical societies is necessary if the intent of the resolutions is to be effectively carried out. It was therefore

RESOLVED, THAT medical societies be urged to investigate, document, and report to the Law Division of the American Medical Association all violations of Public Law 89-97 by officers or employees of the federal government; and be it further

RESOLVED, THAT a status report be provided to this House at the 1967 Clinical Convention.

The chairman would like to express appreciation to the members of the Council on Governmental Medical Services for their work during the year and also to the committee chairmen and members.

The report of the committees covering their activities and recommendations follow.

Recommendations, Reference Committee No. 5

The report of the Council on Governmental Medical Services to the 1967 session of the House of Delegates was reviewed by Reference Committee No. 5, and to facilitate ease and clarity of presentation, it will be divided into (1) Report of the Council, (2) Report of the Technical Advisory Committee on Indigent Medical Care, (3) Report of the Governmental Medical Contracts Committee with the Addendum to the Report of the Governmental Medical Contracts Committee, Page 19, Report No. 16, (4) Report of the ODMC Review Committee, (5) Report of the Advisory Committee on Title XVIII (Social Security Act), (6) Report of the Committee on Appalachian Programs, (7) Report of the Committee on OEO Programs and Addendum to the Report of the Committee on OEO Programs, Page 22, Report No. 16.

The Report of the Council on Governmental Medical Services was reviewed and discussed, not only generally, but specifically. It was quite obvious that the activities of this Council have been numerous and comprehensive. The Council, with perseverence, has met with many frustrations.

The Reference Committee wishes to commend the members of the Council for their excellent work.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Technical Advisory Committee On Indigent Medical Care

Garnett J. Sweeney, M.D., Liberty, Chairman

The KMA Technical Advisory Committee on Indigent Medical Care has met seven times during the calendar year. The committee members have also attended all of the Governor's Advisory Council meetings. Joint meetings have been held with members of other advisory groups, staff members of the State Department of Health (Medical Assistance Division), the Department of Economic Security, Blue Cross-Blue Shield and the Metropolitan Life Insurance Company.

The committee is by necessity a hard-working group. A study of the organization structure of the Medical Assistance Program in Kentucky is a necessary part of our report to point out that this committee can only recommend and that the process of action is often slow.

The KMA Technical Advisory Committee on Indigent Medical Care is a quasi-governmental body, called for by Kentucky Statutes, and is one of six vendor groups, "established for the purpose of acting in an advisory capacity" to the Advisory Council for Medical Assistance Programs for the Commonwealth of Kentucky. The six committees, composed of five members each appointed by their respective associations, represent physicians, hospitals, dentists, nursing, drugs and nursing homes. The committees are on many occasions required to meet on short notice, often in a week or less prior to the Advisory Council sessions. Our committee carries our established KMA policies and reports to the Association the activities of the state program of medical assistance under Title XIX of the Social Security Act.

The U. S. Department of Health, Education and Welfare has contracted with the Kentucky State Department of Economic Security to administer the Title XIX program. This state department handles eligibility status and the writing of checks.

The Department of Economic Security has contracted with the State Department of Health to handle all medical aspects for all vendor groups. This assignment is handled by the Medical Assistance Division of the Department.

The Advisory Council on Medical Assistance, established by Kentucky Statutes, meets at least quarterly to "develop and formulate recommendations to the Department of Health as to policies, plans, budgets, programs, rules and regulations." It is composed of 11 members: the two department commissioners, representatives of the Kentucky Medical Association, the Kentucky Dental Association, the Kentucky Hospital Association, the Kentucky Pharmaceutical Association, and the Kentucky Nurses Association, plus four lay members.

Early in the calendar year one of the big problems was that involving the dual forms required for satisfying the $50 deductible for recipients over 65 covered by both Medicare and Medicaid.

On December 8, 1966, the matter was presented to the KMA Board of Trustees who passed a resolution calling for one simple form to be prepared by January 15, 1967.

This information was presented to the Advisory Council on December 21, 1966, and it was agreed that a simplified form should be devised.

This was accomplished on January 5, 1967, at a meeting attended by your chairman, the Commissioner of the Department of Economic Security and staff members, representatives of the HIB Social Security from Washington representing Title XVIII, representatives from the Metropolitan Life Insurance Company (the Kentucky fiscal agent for Title XVIII), and representatives of the Medical Assistance Division of the State Board of Health.

On March 22, 1967, prior to the Advisory Council, the KMA Technical Advisory Committee met with the Technical Advisory Committee on Drugs. It was agreed to recommend to the Advisory Council that a Formulary Drug Committee be appointed to go into the entire matter of the drug program now in effect in the Kentucky Medical Assistance plan. The same day the Advisory Council accepted the motion and the committee was appointed.

The Formulary Committee met on May 18, 1967, to review the Medical Assistance Program drug list, refill authorization and quantity limitations.

The present drug program costs the state $6 million annually or about $26 per program recipient with the state requiring a mandatory drug list for cost control.

In June, the Technical Advisory Committee met with Francis Land, M. D., consultant from the Department of Health, Education and Welfare, Washington, D. C. The committee members, the KMA President-Elect, and KMA Secretary also had a meeting with the staff members of the Medical Assistance Department of the State Department of Health. After these two meetings, the committee chairman met with the KMA Board of Trustees on June 11 to request policy guidelines relative to drug formularies, x-ray and laboratory fees, fiscal agent, and release of information under the recently completed fee survey.

The KMA Board of Trustees passed the following resolutions which were presented to the Advisory Council for Medical Assistance at their meeting on June 21, 1967.

DRUG FORMULARIES

WHEREAS, we are against a limited formulary in principle, and

WHEREAS, there are at present no Federal Food and Drug Administration biological activity standards established for generic drugs, and

WHEREAS, it has been adequately demonstrated that even though a generic drug meets the standards of the present United States pharmacopoeia and Federal Drug Administration regulations that it may still not have biologic potency in the human,

THEREFORE BE IT RESOLVED, the Kentucky Medical Association opposes the establishment of the provision of drugs under Medicare by generic prescription, and

BE IT FURTHER RESOLVED THAT prescribing by generic drug names not be required under any government regulation or law without first setting up a human biologic activity standards with adequate controls to enforce such standards.

X-RAY AND LABORATORY FEES

WHEREAS, the Kentucky Medical Association opposes dual fee schedules and is on record favoring usual and customary fees wherever feasible in dealing with third parties, and

WHEREAS, recent proposals, June 8, 1967, from the medical director of Title XIX relating to schedule of payments for X-ray and laboratory services to be instituted July 1, 1967, would:

1. *Establish a low schedule of fees for a limited number of procedures allowed in laboratories of physicians' offices who do not employ registered technologists and a high schedule of fees for those who do.*
2. *Establish an unrealistically low schedule of fees for X-ray procedures done in physicians' offices and pay this amount only if films are interpreted by a radiologist.*
3. *Pay radiologists for film interpretation, but pay no other physician fees for the same service.*

WHEREAS, physicians at the inception of Kerr-Mills accepted an unrealistically low fee years before Comprehensive Medical Care became the objective of medical assistance programs, and

WHEREAS, physicians do not think that the philosophy expounded by the Bureau of Family Services in Washington indicates a desire for delivery of low quality services of any kind to its beneficiaries, and

WHEREAS, KMA and Blue Shield have completed a survey of usual and customary physicians' charges in the State of Kentucky, and

WHEREAS, X-ray and laboratory services are included in this survey,

BE IT RESOLVED THAT KMA inform the Governor's Advisory Council and the State Department of Health that henceforth this usual and customary fee survey should be the foundation upon which payments to physicians are made and that we reject the idea of limited and divisionary laboratory and X-ray fees as prepared by the Department of Medical Services, June 8, 1967.

AND BE IT FURTHER RESOLVED THAT KMA inform the Department of Medical Services that results of the usual and customary fee study will be made available to them at the earliest possible date so that they can forthwith begin paying for all physicians' services on a usual and customary basis.

RELEASE OF INFORMATION ON FEE SURVEY

RESOLVED that the KMA Board of Trustees authorize the KMA Board Executive Committee and KPM, Inc. to release to the Kentucky Department of Health the statistical average of fees studied, by procedure, for the purpose of doing a feasibility study to determine the predicted cost of covered services under Title XIX in Kentucky if the benefits are provided and services paid under the usual, customary and reasonable concept.

The Chairman and the committee members would be remiss if they did not express sincere gratitude to G. L. Simpson, M. D., for his many years of fine service, guidance, and counsel as chairman of the Advisory Council. The new KMA member of the Governor's Advisory Council is E. C. Seeley, M. D.

As chairman, I wish to express my sincere gratitude to the committee members for their valued advice, assistance and excellent attendance at all meetings.

This committee continues to have a difficult assignment and is fully cognizant of its responsibilities to the physicians and the people of Kentucky. By remaining active in these programs, we will continue to try to influence the direction in the best interest of the patients.

Recommendations, Reference Committee No. 5

Doctor Garnett Sweeney and his associates have worked hard and long in the interest of the Kentucky Medical Association in an attempt to work out programs with the State Department of Health which are in keeping with the principles of the Kentucky Medical Association.

The report itself and the discussion which revolved about it illustrate disappointments the Kentucky Medical Association has experienced in dealing with Governmental agencies in an effort to provide the very best care to patients under the philosophies of the Kentucky Medical Association.

It should be noted that no increase in the formulary has occurred despite the activities of this committee and that their efforts to establish the usual and customary fees for x-ray and laboratory services were used by the State Department of Health to establish a fee schedule which was not usual and customary, but predominant.

However, the persistent efforts of this committee and its chairman would appear to have brought the state and KMA nearer to a point of accord, but continued vigilance and hard work will be needed to achieve the goals of the Kentucky Medical Association. This committee should be commended by the Kentucky Medical Association for outstanding work.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Governmental Medical Contracts Committee

Douglas Atherton, M. D., Louisville, Chairman

CHAMPUS CONTRACT (Pertaining to Dependents of Armed Forces Personnel)

On November 3, 1966, representatives of your committee met with Brig. Gen. N. E. Peatfield, Executive Director of the Office for Dependents' Medical Care, for the purpose of revising the contract to allow payment for services on the basis of usual and customary fees.

The General pointed out that the intent of enabling legislation already allows payment of usual and customary fees, but that his office must know what these fees are in order to estimate budgets and to determine which claims qualify for referral to our own CHAMPUS Review Committee.

Background data and the substance of this meeting are contained in a letter dated November 4, 1966, sent to all members of this committee.

Kentucky Blue Shield has been empowered by the 1966 KMA House of Delegates to conduct a survey on state-wide usual and customary fees. This survey, due to be completed about July, 1967, will accumulate information suitable for revising the CHAMPUS contract.

The Committee agreed to recommend to the Board of Trustees:

(1) That the present CHAMPUS Contract be extended approximately six months, or until such time as the survey on usual and customary fees is completed.

(2) That outpatient services for eligible persons, as enabled by recent legislation, be included in the present contract on the basis of usual and customary fees, and, until a new contract can be negotiated, such uncharted fees submitted be reviewed by the KMA CHAMPUS Review Committee.

(3) That the Review Committee be enlarged to include members more representative of the whole state.

These items were approved by the Board of Trustees at their December 7, 1966 and April 18, 1967 meetings.

At the committee meeting of June 7, 1967, Blue Shield representatives reported on progress of the survey of state-wide usual and customary fees, indicating this would be complete and ready for utilization by about mid-July, 1967.

The committee requested the KMA Board of Trustees to empower Kentucky Blue Shield to release such information from the survey after its completion to both CHAMPUS and V. A. Home Town contracting sources as to make it possible for this committee to negotiate new contracts with both when it

meets for this purpose in August, 1967. It was thought best to try to conclude this matter prior to the KMA meeting in September, to make best use of committee members who are presently familiar with the problem.

V. A. HOME TOWN CONTRACT

At the committee meetings of November 30, 1966, and June 7, 1967, Doctors Van Biesen and Soderberg of the V. A. were present and agreeable to negotiating a revised contract based on usual and customary fees when the Blue Shield survey is completed. The present contract is extended through August, 1967.

Doctor Soderberg informed us of the innovation of I. D. cards, now included, to simplify billing and administration.

SUBCOMMITTEE REPORT ON FORM SIMPLIFICATION

Doctors Bushey and Prewitt, voicing a common complaint about time and cost necessary to complete insurance and government forms relating to medical services, undertook to tabulate factual information. Doctor Bushey reported that a Blue Shield form takes about seven minutes, CHAMPUS form about 15 minutes, and the KMA standard form about eight minutes.

It was pointed out that CHAMPUS will have a new and, hopefully, simplified form available July 1, 1967.

No recommendation was made to charge for filling out this sort of information form. It was assumed that it office administration costs rise sufficiently as a result of these, then medical service charges to patients must be adjusted upward.

A recommendation was forwarded to our delegate to the AMA that this organization move with its weight to shorten time necessary to deal with these forms.

Addendum To The Report Of The Governmental Medical Contracts Committee

Your committee met again on Wednesday, August 16, 1967, to clarify the fee situation involved in caring for dependents of the Armed Services personnel (the previous CHAMPUS Contract).

On August 3, 1967, a communication from Brigadier General Norman E. Peatfield, Executive Director of CHAMPUS, stated that a three-party contract between this government service, a carrier, and a state medical society, will no longer be necessary, and that in the future a contract will be arranged between CHAMPUS and a carrier based on the concept developed by the Social Security Administration and following its "usual, customary, and reasonable" fee program.

CHAMPUS was represented at this meeting by Lieutenant Colonel Robert Holzworth, M.D., who further elaborated on this change. Your committee felt it was expressly following the wishes of the Kentucky Medical Association in strongly recommending:

1. Express provision for a KMA-appointed Advisory Committee of Physicians to work with the carrier to help define this fee concept and to act as liaison for resolution of any problems arising between the carrier and the physician community;
2. Provision for periodic revision of "usual, customary, and reasonable" fees;
3. Provision for a KMA-appointed Review Committee for the purpose of judging any unusual fees;
4. Since Kentucky Blue Shield has recently completed an extensive survey of Kentucky physicians' fees in a way that appears to be as comprehensive and accurate as possible, we feel that without reservation, the Kentucky physicians would strongly prefer that Kentucky Blue Shield continue as carrier for this program.

The substance of the above was then addressed in writing to Brigadier General Peatfield.

VA HOME TOWN

The second major item of business was revision of the VA Home Town Contract, and Doctor Bernard Soderberg, representing that government office, was present for this discussion. A previous communication from Doctor Soderberg indicated a revision in some of the fees allowed, but neither his information nor your committee's information could verify whether the present maximum fee allowed for these services did, in fact, represent usual, customary, and reasonable fees.

It was the wish of your committee that the recently completed fee survey by Kentucky Blue Shield in some fashion be made available to this office of the Veteran's Administration so that it could revise its payments with a "reasonable limitation" based upon customary and usual fees. However, the KMA Board of Trustees at its August 2, 1967, meeting made the following motion:

> "In this instance (VA Home Town) no statistics will be furnished, and it was agreed that the contract will continue in its present state until it is brought up to the House of Delegates since there is a 30-day notice to discontinue the contract by either party."

Your committee, therefore, moved and passed a recommendation that the House of Delegates authorize Blue Shield to release such information for this purpose. It was Doctor Soderberg's belief that this information could result in a new contract based upon usual and customary fees. Such information should be accompanied by a letter giving our very sound reasons for requesting such a change.

Present at this meeting were four representatives of Kentucky Blue Shield who were able to point out to Colonel Holzworth and Doctor Soderberg the merits and validity and possible application of this recently completed survey.

Recommendations, Reference Committee No. 5

The report of the above committee with the Addendum to the Report of the Governmental Medical Contracts Committee, page 19, Report No. 16, was reviewed. A great deal of effort has been exerted by this committee in attempting to establish contracts permitting the payment for services on the basis of usual and customary fees. It would appear at the present time that the usual and customary fee concept has been accepted by the government agency with whom these contracts are being negotiated (CHAMPUS and VA Home Town).

The Reference Committee wishes to commend Doctor Atherton and his committee for their strong efforts, and recommends continued efforts in this area.

Mr. Speaker, I move the adoption and implementation of this section of the report.

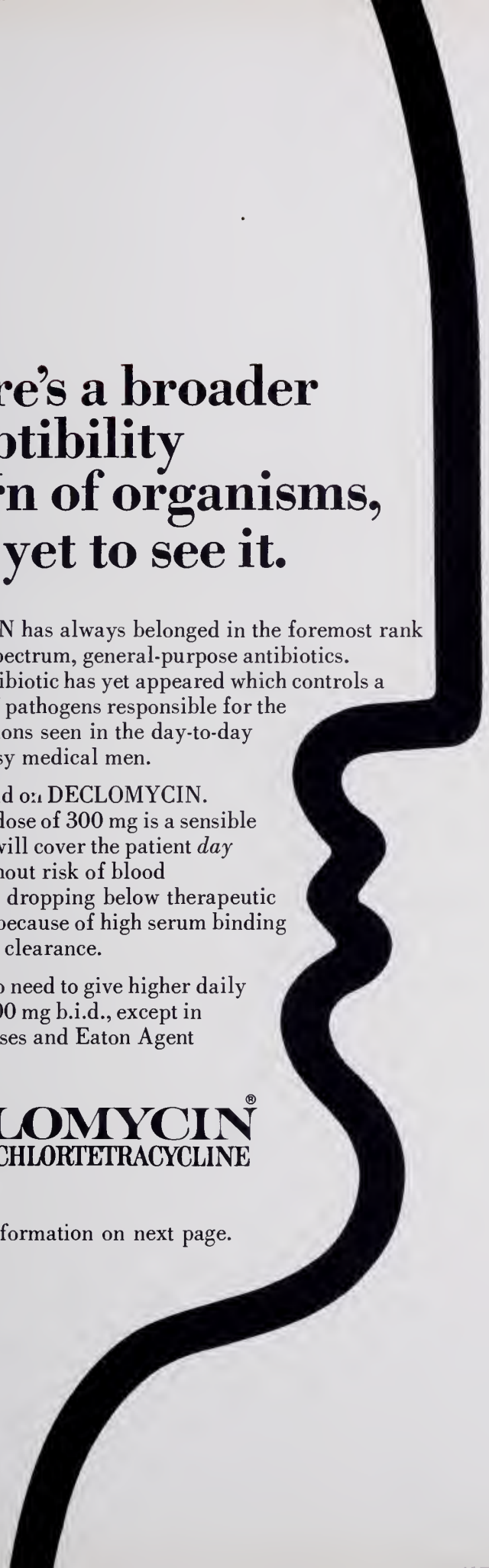
(Motion seconded and carried.)

ODMC Review Committee

W. H. Powers, M. D., Louisville, Chairman

During 1967, the committee, with members representing the various medical fields, reviewed charges submitted by private physicians on care for medical dependents. It was felt that since no major changes were made in the charges or in the manual outlining the usual charges, that it was not necessary to have a joint meeting of this committee during the past year. Rather, the committee functioned more on an individual basis with the respective members reviewing cases submitted to them which related to their particular field.

The committee functioned well and there were no major difficulties reported.



Eaton Agent

Endamoeba histolytica

Hemophilus influenzae

If there's a broader susceptibility pattern of organisms, we've yet to see it.

Pneumococcus

Escherichia coli

DECLOMYCIN has always belonged in the foremost rank of the broad-spectrum, general-purpose antibiotics. Indeed, no antibiotic has yet appeared which controls a wider range of pathogens responsible for the clinical infections seen in the day-to-day practice of busy medical men.

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You can depend on DECLOMYCIN. A twice-daily dose of 300 mg is a sensible schedule that will cover the patient *day and night*, without risk of blood concentrations dropping below therapeutic levels. This is because of high serum binding and slow renal clearance.

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DEMETHYLCHLORTETRACYCLINE

Lederle

Streptococcus

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Rickettsia

Treponema

Eaton Agent

Endamoeba histolytica

Hemophilus influenzae

Pneumococcus

Escherichia coli

Gonococcus

Shigella

Staphylococcus

Streptococcus

Rickettsia

Treponema

If there's a broader susceptibility pattern of organisms, we've yet to see it.

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is affected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.

Lederle

486-7—5993A

Recommendations, Reference Committee No. 5

This report has been studied and discussed.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Advisory Committee on Title XVIII (Social Security Act)

Paul J. Parks, M. D., Bowling Green, Chairman

The Advisory Committee on Title XVIII (Social Security Act) met once during the year on January 11, 1967, with all members, the Kentucky Medical Association Secretary, Executive Secretary, and Kentucky Medical Association Assistant Executive Secretary present, as well as a representative from Blue Cross-Blue Shield and from Metropolitan Life Insurance Company. Problems considered by the committee and guests included those related to the usual, customary, and reasonable charges as related to the Title XVIII Program and the committee agreed that this should be the mode of determining payment after the Kentucky Medical Association fee survey report had been compiled.

There was objection by members of the committee and by other physicians in the Commonwealth to the method of certification for admission of medical patients to hospitals and Extended Care Facilities. This was recognized as a requirement of the present Social Security Act, and this objection was passed on to the American Medical Association for information to be used in amending the act as it regards certification.

The method of payment under Medicare for services of interns, residents, and house officers was reviewed and felt to be in compliance with policies of the American Medical Association, and further study at this time was not felt to be necessary.

The committee discussed with Mr. Don Smith of Metropolitan some problems with reference to wording on the "Explanation of Benefits Form" used by the company to inform patients about payments of their medicare bills. Specifically, there was physician objection to using the wording "reasonable charge" on the form, which it was felt implied to the patient, whose bill was involved, that charges submitted by his physician might be "unreasonable." Mr. Smith was very cooperative about this, and on the next forms corrected the wording as recommended by the committee. The form now says that, "The above payments are made in accordance with Title XVIII, Medicare Act."

A single form for physician's request for payments for patients on both Medicare and Medicaid was discussed and the form worked up by Doctor Sweeney and his committee was approved and later sent to all physicians involved in both medical programs.

A letter suggested by Metropolitan for mailing to all physicians in Kentucky, spelling out how to handle Medicare patients, was rejected and a simpler form recommended. This was later compiled by Metropolitan, found to be acceptable by the committee and later mailed to a physicians in the state.

Several letters have been received from private physicians during the year, numerous reports from the American Medical Association, and volumes of material from Health, Education, and Welfare. These have been reviewed, comments made to proper offices when deemed advisable, and much effort made to make Title XVIII workable for the private physician and his patient.

The chairman wants to take this opportunity to thank all of the members of the Title XVIII Committee and all those who contributed to its functions during the year.

Recommendations, Reference Committee No. 5

The report of this committee was studied in detail. It should be noted that the Committee met twice, instead of the stated once in the report, the last meeting being held on September 6, 1967. Doctor Parks presented the matters discussed on the last occasion, in person. A great deal of work has been carried on by this committee in establishing liaison with the fiscal agent, which has resulted in improvement in the processing and understanding of claims under Title XVIII.

This committee is to be commended for its work.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Committee on Appalachian Programs

Meredith, J. Evans, M.D., Middlesboro, Chairman

There was no called meeting of this committee in 1967. A meeting was held on September 20, 1966, at Louisville with Doctor George Archer, Doctor Ballard Cassady, and the chairman in attendance. Area-wide Health Facility Planning was the primary topic of discussion. There are plans for 20 multicounty health centers in Kentucky. These are to contain diagnostic and treatment centers and *other* facilities necessary to health. These centers are to be financed through federal grants for construction and operation. It was felt that our present County Health Departments would be replaced and more responsibility shifted to the state and regional levels. It was recommended that members of the medical profession be active on these committees and influence their course.

Appalachian Regional Hospitals, Inc. was discussed. The following observations were made:

(1) Doctors' offices remain in the hospitals and appear to be on the increase.

(2) Foreign interns and residents are being utilized by Daniel Boone Clinic.

There were no recommendations.

Many aspects of governmental medicine affect Appalachia, but these are covered by other committees.

Recommendations, Reference Committee No. 5

It was noted there were no called meetings of this committee in 1967. The notation of the Board action regarding this report was recognized.

It was felt by Reference Committee No. 5 that the portion of this report following the first sentence was not germane to the activities of this committee, being covered by other councils and committees, and should be deleted.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried.)

Committee on OEO Programs

Harry U. Whayne, Jr., M.D., Murray, Chairman

This committee has had one meeting during the fiscal year which was held on December 7, 1966. At this meeting, the following motions were made, which were later approved by the Council and the KMA Board of Trustees at their April 18, 1967 meeting:

That KMA endorse the action taken by the AMA Board of Trustees who noted the need for organized medicine to participate in a consultative role in the many programs concerned with health now developing under the aegis of the Office of Economic Security.

That the Committee on OEO Programs establish an informational service on various OEO programs to the County Societies.

It is urged by this committee that local communities advise the KMA Headquarters Office of any new projects in their areas so that we would eventually have a central source of information. This could serve as a two-way flow of information both to committee members and to communities interested in similar projects in other sections of the state.

The Chairman wishes to extend his appreciation to his committee members for their contributions.

Addendum to the Report of the Committee on OEO Programs

AMERICAN MEDICAL ASSOCIATION POLICY REGARDING GOVERNMENT MEDICAL CARE PROGRAMS

Guidelines

1. "The medical profession in any community is best represented by the local medical society and its officers. They should be consulted initially, and during the process of planning of any and all projects for the care of the sick and the preservation of health. Physician members should be placed at a policy making level and should be voting members of the guiding body of such projects.

2. The need for any new facility shall be first established by persons who are knowledgeable. It shall be first determined that exisiting facilities are so inadequate that only a completely new facility will provide a solution. The local medical society must cooperate and lend assistance in all such studies.

3. It is suggested that the tax dollar might better be conserved by making funds available to already existing facilities in correcting deficiencies and providing personnel.

4. The responsibility for the health needs of a community basically resides at the community level, and all the local resources of the area, private, voluntary and public health shall be examined *before* the community accepts government monies.

5. If it is deemed advisable to operate a government financed facility in a community, it shall in no way be binding upon a physician to refer his patients there, to coerce a physician to service the facility, and this facility must in no way infringe upon the private practice of medicine.

6. These projects should not be developed or operated in such a manner as to establish a precedent that could lead to a governmental controlled medical care system in this country."

COUNCIL ON GOVERNMENTAL MEDICAL SERVICES
L. Douglas Atherton, M.D., Louisville
J. Meredith Evans, M.D., Middlesboro
Garnett J. Sweeney, M.D., Liberty
Harry U. Whayne, Jr., M.D., Murray
Paul J. Parks, M. D., Bowling Green, Chairman

Recommendations, Reference Committee No. 5

The report of this Committee was studied and discussed with the Addendum to the Report of the Committee on OEO Programs, Page 22, Report No. 16. The recommendations of this Committee are heartily endorsed by Reference Committee No. 5, and the participation of medicine in a consultative role in the many programs concerned with health should be encouraged. Not only should local communities advise the Kentucky Medical Association Headquarters Office of any new projects, but it was the feeling of the Reference Committee that any information pertaining to such projects by the Kentucky Medical Association Headquarters should be promptly called to the attention of societies or physicians in the areas.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Mr. Speaker, I move the adoption and implementation of Report No. 16, the Report of the Council on Governmental Medical Services.

(Motion seconded; carried.)

Supplemental Report B
Report of the Chairman of the Board of Trustees

Consideration was given by the Board of Trustees at the called meeting, June 11, relative to the advantages of a fiscal agent for the Title XIX program in Kentucky. After full consideration, the following resolution to be presented to the KMA House of Delegates was passed by the Board without dissent:

RESOLVED that the Board of Trustees recommend to the House of Delegates that the policy of this Association be as follows:

WHEREAS the Kentucky Physicians Mutual, Inc., is the only private agency with the necessary staff, equipment, information and ability to implement Title XIX in Kentucky.

THEREFORE BE IT RESOLVED THAT the Kentucky Physicians Mutual Inc., be appointed as the fiscal agent for Title XIX in this state, and

BE IT FURTHER RESOLVED THAT KMA no longer urge its members to participate in Title XIX until such time as Kentucky Physicians Mutual, Inc., is appointed as the fiscal agent for Title XIX in this state.

Rex E. Hayes, M.D., Chairman
Board of Trustees

Resolution N

Fayette County Medical Society

WHEREAS there have been many objections to the State Health Department being the fiduciary agent under Title XIX,

THEREFORE BE IT RESOLVED that a private insurance agent with the necessary staff, equipment, information, desire, and ability be appointed as a fiscal agent for Title XIX in this state, and

BE IT FURTHER RESOLVED that when this resolution is adopted that the Board of Trustees of the Kentucky Medical Association work toward achieving this end, and

BE IT FURTHER RESOLVED that the Kentucky Medical Association no longer urge its members to participate in Title XIX until such time as a private insurance agent is appointed as the fiscal agent for Title XIX in this state.

Recommendations, Reference Committee No. 5

SUBJECT: FISCAL AGENT FOR TITLE XIX

Consideration was given to the resolution contained in Supplemental Report B by the Board of Trustees at their called meeting on June 11, 1967, relative to the advantages of a fiscal agent for the Title XIX Program. This resolution and Resolution N both have the same objectives. It is felt that the Fayette County Resolution N, not naming a specific fiscal agent, is in accord with the principles of free enterprise voiced on many occasions by this Association. It was also recognized that Kentucky Physicians Mutual, Inc. has, in the past, rendered invaluable service to this Association and certainly should be given every consideration.

It is recommended by Reference Committee No. 5 that the following substitute resolution be adopted:

WHEREAS there have been many objections to the State Health Department being the fiduciary agent under Title XIX,

THEREFORE BE IT RESOLVED that a private fiscal agent with the necessary staff, equipment, information, desire, and ability be appointed as a fiscal agent for Title XIX in this state, and

BE IT FURTHER RESOLVED that when this resolution is adopted that the Board of Trustees of the Kentucky Medical Association work toward achieving this end, and

BE IT FURTHER RESOLVED that the Kentucky Medical Association no longer urge its members to participate in Title XIX until such time as a private fiscal agent is appointed as the fiscal agent for Title XIX in this state.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded.)

In the discussion that followed this motion, a motion was made and seconded to amend this report

by removing the section on Supplemental Report B, Report of the Chairman of the Board of Trustees and Resolution N (Fayette County) from the report and remanding it to the Board of Trustees. The motion was defeated.

A motion was made to amend the substitute resolution recommended by Reference Committee No. 5 by having the second resolve be changed as follows:

"BE IT FURTHER RESOLVED that when this resolution is adopted that the Board of Trustees of the Kentucky Medical Association work toward legislation to achieve this end," and strike the entire last resolve. Motion seconded and carried, thus making the action of the House on the reference committee substitute resolution read as follows:

WHEREAS there have been many objections to the State Health Department being the fiduciary agent under Title XIX,

THEREFORE BE IT RESOLVED THAT a private fiscal agent with the necessary staff, equipment, information, desire, and ability be appointed as a fiscal agent for Title XIX in this state, and

BE IT FURTHER RESOLVED that when this resolution is adopted that the Board of Trustees of the Kentucky Medical Association work toward legislation to achieve this end.

(The original motion as amended passed.)

Supplemental Report C
Report of the Chairman of the Board of Trustees

During the Associational year just closing, your Board of Trustees has spent many hours discussing the implementation of Title XIX, the medical welfare program in Kentucky often referred to as Medicaid. On various occasions, your chairman, along with other officers of the Association, has met with the KMA Technical Advisory Committee (ably chaired by Garnett Sweeney, M.D., Liberty) and officials of the Medical Care Division and the Commissioner of Health.

From time to time, this Board has authorized general letters to every KMA member, advising you of developments in this area. (Information was also distributed on implementation of Resolution A passed by this House in 1966). The Journal of KMA and the Communicator have been used to keep you informed on this general subject. As this report is written, the last letter from the Department of Health to all Kentucky physicians, dated July 18, 1967, and known as "# A-19," related to fees for laboratory and X-ray services. In a letter dated July 27, signed by the Chairman of the Board, the reaction of the Executive Committee of the Board toward the Health Department's letter # A-19 was spelled out.

At the August 3 meeting, Russell E. Teague, M.D., Commissioner of Health and Mr. Evan Ray, Director of the Division of Medical Care that administers Title XIX in Kentucky, met with the Board on the entire problem. It was pointed out in these discussions that the 1966 meeting of the KMA House of Delegates had adopted the policy that KMA not participate in any governmental programs which did not embrace the usual and customary fee concept.

The state officials assured the members of the Board that the usual and customary fee concept would be used at a very early date for all outpatient services the program covered. No definite date was given for compensating physicians for services rendered to inpatient recipients on the usual and customary basis.

On the question of when and how much information would be released to the Division of Medical Care by the Blue Shield concerning the results of the recent confidential fee survey that was made because of the passage by this House of Resolution A in 1966, the Board on August 3, 1967, passed the following motion:

RESOLVED, that upon receipt of written assurance from the State Department of Health and Economic Security of their commitment to the concept of paying physicians their usual, customary and reasonable fees for their services under governmental programs; of their acceptance of the premise that the reasonableness of a fee will not be questioned unless it falls above the 90th percentile; and of their intention to implement such payment method for out-of-hospital services at the earliest possible time, *preferably* by the third week in September, 1967, this Board authorizes the release to the Department of Health by Kentucky Physicians Mutual, Inc., of the results (exclusive of individual profiles) of the recently conducted fee survey.

Later in the same meeting, the Board passed the following resolution on the Medicaid matter:

WHEREAS, the financial ability of the Commonwealth of Kentucky to provide medical services in and out of the hospital, under Title XIX, and to pay physicians the usual and customary fee for such services, is determined, according to Doctor Teague for Mr. Ray, by the monies which are made available through the appropriations of the Kentucky General Assembly, and,

WHEREAS, the Kentucky Medical Association has no data to evaluate the validity of budgetary requests to support the Title XIX program under the usual and customary fee concept,

THEREFORE, BE IT RESOLVED THAT:

(1) The Kentucky Department of Health determine on sound actuarial basis the annual projected cost of providing medical services, in and out of the hospital under Title XIX on the usual and customary fee concept with the 90th percentile being used to determine the maximum payment permitted, and

(2) BE IT FURTHER RESOLVED that if the Kentucky Department of Health is unable to develop a sound, actuarial estimate of the cost of such a program that the Kentucky Department of Health be requested to provide Blue Shield the necessary statistical data so that Blue Shield may estimate the projected annual cost of paying physicians under the 90th percentile concept, the usual and customary fee for medical services rendered both in and out of the hospital.

(3) BE IT FURTHER RESOLVED, that such estimate of cost, as described above, be made available to the Board of Trustees no later than thirty days prior to the next session of the Kentucky General Assembly.

Rex E. Hayes, M.D., Chairman
Board of Trustees

Recommendations, Reference Committee No. 5

The report of the Chairman of the Board of Trustees, Supplemental Report C, Page 23 through 25, was reviewed.

It was noted that the Board, on the 3rd of August, 1967, passed the following motion:

RESOLVED, that upon receipt of written assurance from the State Departments of Health and Economic Security and their commitment to the concept of paying physicians their usual, customary, and reasonable fees for their services under Governmental programs; of their acceptance of the premise that the reasonableness of a fee will not be questioned unless it falls above the 90th percentile; and of their intention to implement such payment method for out-of-hospital services at the earliest possible time, *preferably* by the third week in September, 1967, this Board authorizes the release to the Department of Health by Kentucky Physicians Mutual, Inc., of the results (exclusive of individual profiles) of the recently completed fee survey.

This, with a resolution on Page 24 of the Report of the Chairman of the Board of Trustees, was adopted in an effort to cooperate with the Kentucky Department of Health in establishing Title XIX on a sound actuarial basis.

It was pointed out in the discussion in the Reference Committee that the 90th percentile was creating objections on the part of the Kentucky State De-

partment of Health. Because of this concern of the Department of Health, the Board of Trustees, on the 24th of September, 1967, moved and passed the following:

That the 90th percentile limitation be removed from the resolution that was sent to the Department of Health at the last meeting of the Board of Trustees (August 2 and 3, 1967), and stipulate that they proceed with the implementation of the "usual and customary fee" program recognizing the need for a maximum cut-off point and that the State Department of Health calculate this cutoff point statistically and reach an agreement on it with the Technical Advisory Committee.

It is understood by Reference Committee No. 5 that information is to be released to the Department of Health only on assurance in writing from proper authority that the statistical data submitted by the Kentucky Medical Association will not be used for any other purpose than the development of payment of usual and customary fees for both in-patient and out-patient care.

Mr. Speaker, I move the adoption and implementation of this report.

(Motion seconded; carried.)

Resolution F

Fayette County Medical Society

WHEREAS the Commonwealth of Kentucky established a fee schedule for the payment of physicians under Medicaid which was totally unacceptable to the medical profession of this Commonwealth, and

WHEREAS the Board of Trustees of the Kentucky Medical Association has previously informed the Governor's Health Advisory Council for Indigent Care that if the Kentucky State Department of Health did not change to payment on the basis of usual and customary fees that it would no longer urge its members to participate under Medicaid, and

WHEREAS to assist the state in switching to a usual and customary payment basis, an expensive survey of the usual fees of the physicians in Kentucky has been completed, and

WHEREAS the State Department of Health notified physicians by publication labeled A-19 dated July 18 of a fee schedule for laboratory and X-ray studies based on predominant fees from the survey rather than usual and customary fees, and

WHEREAS no action has been taken to cancel this schedule despite the letter from Rex Hayes, M.D., Chairman, Board of Trustees, Kentucky Medical Association, dated July 28 directed to the Commissioner of Health which requested substitution of a usual and customary fee,

THEREFORE BE IT RESOLVED THAT the Kentucky Medical Association no longer urge its members to participate in Medicaid until fees are paid under a usual and customary concept.

Recommendations, Reference Committee No. 5

Resolution F of the Fayette County Medical Society was reviewed and discussed. It was brought out that the following motion had been passed by the Kentucky Medical Association Board of Trustees on Sunday, September 24, 1967:

That the Board of Trustees endorse in principle Resolution F (Fayette County), and ask the House of Delegates to adopt a positive stand on usual and customary fees, but with a 90 day limitation for its implementation.

Reference Committee No. 5 recommends that the resolved, which now reads

THEREFORE BE IT RESOLVED that the Kentucky Medical Association no longer urge its members to participate in Medicaid until fees are paid under the usual and customary concept,

be changed to read,

THEREFORE BE IT RESOLVED that unless, within 90 days, the Departments of Health and Economic Security implement, within present budgetary limitations, a plan for the payment of physicians' usual, customary, and reasonable fees for all services rendered to patients entitled to indemnities under governmental programs administered by either or both of those departments, this Association advise its entire membership that it no longer urges them to cooperate in any way with the state in administration of these programs.

Further, copies of this resolution, if approved by the House, be sent to the Kentucky State Department of Health, the Kentucky Department of Economic Security, and Secretary Gardner of the United States Department of Health, Education and Welfare.

Mr. Speaker, I move the adoption and implementation of this section of the report.

At this point, the Speaker recognized Rex E. Hayes, M.D., Chairman of the Board of Trustees, who introduced the following resolution passed by the Board on September 27 and moved that it be substituted for the Reference Committee recommended change in the resolve of Resolution F:

THEREFORE BE IT RESOLVED that unless, within 90 days, the Departments of Health and Economic Security implement a plan for the payment of physicians' usual, customary, and reasonable fees for all services rendered to patients entitled to indemnities under governmental programs administered by either or both of those departments, which plan shall include the provision of adequate funds in the budget for the next biennium, this Association advise its entire membership that it no longer urges them to cooperate in any way with the state in administration of these programs.

Motion was seconded. In the following discussion, a motion was made to amend the Board's resolution by adding the words "in and out of hospitals" following the phrase "for all services rendered to patients". Motion seconded and carried.

The original motion as amended carried and reads as follows:

THEREFORE BE IT RESOLVED that unless, within 90 days, the Departments of Health and Economic Security implement a plan for the payment of physicians' usual, customary, and reasonable fees for all services rendered to patients in and out of hospitals entitled to indemnities under governmental programs administered by either or both of those departments, which plan shall include the provision of adequate funds in the budget for the next biennium, this Association advise its entire membership that it no longer urges them to cooperate in any way with the state in administration of these programs.

Resolution I

Fayette County Medical Society

WHEREAS, it is now accepted KMA policy that all contracts with government agencies be on the basis of payment to physicians for usual, customary, and reasonable fees, and

WHEREAS, the House of Delegates in September, 1966, by approving Resolution G decided that the Kentucky Medical Association terminate as soon as practical all contracts made by the KMA with government agencies which conflicted with KMA policy, and

WHEREAS, the present reorganization plan to be voted on at the 1967 meeting of the House of Delegates included a commission to negotiate contracts for the members of KMA;

THEREFORE BE IT RESOLVED THAT if such a commission is approved that it may only negotiate contracts for members of KMA, concerning physician fees, based on usual, customary and reasonable fees.

Recommendations, Reference Committee No. 5

Resolution I was discussed by Reference Committee No. 5. It is felt that this resolution is a re-

iteration of accepted KMA policy. This policy must be carried over to the re-organized structure of the Kentucky Medical Association.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded; carried.)

Report of the Advisory Committee to Selective Service

The purpose of this Committee, which is quasi-governmental, is to try to maintain an appropriate balance and distribution of medical care for our people, as well as the Armed Forces.

With the escalation of the war in Viet Nam, the call for the past several years has included any physician under thirty-five years of age who has not completed his military obligation.

This Committee, adhering to the regulations issued by the Selective Service Headquarters in Washington, reviews cases and makes recommendations to the Kentucky Selective Service Headquarters. In this connection, it should be pointed out that the State Office in Frankfort can only recommend to a county board that a man be deferred, with the local board having final authority in the state, but normally the recommendations are accepted. This year, the national call was for approximately 2,000 physicians. with a prorated percentage allotted to Kentucky.

We have had excellent cooperation on the part of State Selective Service, and are indebted to the KMA Headquarters Staff for much basic information required by the Committee. Your Committee has been most conscientious, and if any mistakes were made, this is most regrettable.

ADVISORY COMMITTEE TO SELECTIVE SERVICE
J. Duffy Hancock, M.D., Chairman, Louisville
Glenn U. Dorroh, M. D., Lexington
George P. Archer, M.D., Prestonsburg
Charles B. Billington, M.D., Paducah
Sydney G. Dyer, M.D., LaCenter
Sam A. Overstreet, M.D., Louisville
Donn L. Smith, M.D., Louisville
Russell E. Teague, M.D., Frankfort
L. O. Tommey, M.D., Bowling Green
Tom F. Whayne, M.D., Lexington

Recommendations, Reference Committee No. 5

The report of the Advisory Committee to Selective Service was discussed by members of Reference Committee No. 5. It is regrettable that we had no knowledgable members of the Advisory Committee to Selective Service present to inform us of what success this committee has had in dealing with Kentucky Selective Service Headquarters.

Some concern was expressed by members of the Reference Committe that not infrequently recommendations of the Advisory Committee have been overruled. In the future statistical information regarding their success would be helpful in determining how effective this committee is in providing the best services for both the Armed Forces and the citizens of Kentucky. This is not to be construed in any way as derogatory to this hard-working Advisory Committee, but to emphasize the many problems with which they are confronted. They are to be commended most heartily for carrying out a most difficult and unhappily necessary assignment with good effort.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 5 as a whole as amended.

(Motion seconded; carried.)

Mr. Speaker, I wish to express my personal deep appreciation to the members of this committee who worked very thoughtfully and constructively to organize this report.

REFERENCE COMMITTEE NO. 5
Andrew M. Moore, M.D., Lexington, Chairman
James L. Ferrell, M.D., Paris
Walter Johnson, M.D., Paducah
Robert E. Norsworthy, M.D., Hartford
William M. Wyatt, M.D., Somerset

At this time, Doctor Greathouse recognized John C. Quertermous, M.D., Chairman of the KEMPAC Board, who presented a brief talk on the importance to KMA of having its membership support and participate in KEMPAC and AMPAC.

REFERENCE COMMITTEE NO. 6

W. Vinson Pierce, M.D., Chairman

Reports on Constitution and Bylaws and Special Committees

Reference Committee No. 6 considered the following reports:

17. Report of the Judicial Council
18. Report of the Advisory Committee to the Editor
19. Report of the Constitution and Bylaws Committee
20. Report of the Insurance Review Board
21. Report of the Committee on Arrangements for the Interim Meeting

5. Supplemental Report A—Report of the Chairman of the Board of Trustees
   Resolution D—AMA Membership—(Muhlenberg County)
   Resolution Q—Qualified Osteopaths as Members of State Medical Association (Fayette County)

Report of the Judicial Council

The Judicial Council held three meetings during 1966-67 and considered twenty complaints and other matters of various kinds. As was explained to you in our report last year, because of the confidentiality of the Council's records, we do not report the details of our activities. However, we can and do attempt to keep you informed of the general nature of our work.

Much of our work this year has involved complaints of patients who claim they were mistreated in some way. These usually have not involved ethics, as such, but more often, disagreements with the medical judgment of the attending physician. There were two complaints about fees, both of which are still under consideration.

The Council has conducted a searching inquiry into physician participation in drug repackaging, our investigation having antedated the work of the Subcommittee on Antitrust and Monopoly of the Senate Judiciary Committee. Senator Hart's publicity-seeking hearings produced a press release to the effect that 5,000 physicians owned stock in repackaging houses. Two requests to the Senator failed to produce the name of a single Kentucky physician.

With the possible exception of one physician, we have ascertained that all members who ever had stock in repackaging houses have now disposed of their stock, and we are informed that this one physician has also done so. Accordingly, we are confident that physician participation in drug repackaging in Kentucky is insignificant, if not non-existent.

We have expressed the opinion, upon request, that it would be unethical for a physician to submit a bill to Blue Shield for anesthetics administered by a nurse anesthetist, and have recommended that Blue Shield modify its payment procedures so as to permit policyholders to obtain indemnity for anesthetics administered in the smaller hospitals which do not have anesthesiologists.

The relation of in-hospital specialists to their hospitals remains unresolved. We have ruled that hospitals may not purvey medical services to the public

and that if these physicians permit hospitals to bill patients for their services, the bills must be submitted in the names of the physicians and collections paid over to the physicians, less a reasonable bookkeeping and collection charge. Because of the uncertainty of the situation during the implementation of Medicare, we have temporarily withheld enforcement of our ruling; but this moratorium will not continue indefinitely.

We have refused to go so far as to say that it is unethical for physicians to contract with a hospital to man its emergency room on a guaranteed income basis, but have expressed the opinion that they should perform this function on a fee-for-service basis and take their chances on earning the guaranteed minimum.

The next meeting of the Council will be held on October 19, 1967.

THE JUDICIAL COUNCIL
Henry B. Asman, M.D., Louisville
John Dickinson, M.D., Glasgow
J. Duffy Hancock, M.D., Louisville
Clyde C. Sparks, M.D., Ashland
N. L. Bosworth, M.D., Lexington, Chairman

Recommendations, Reference Committee No. 6

The Report of the Judicial Council was covered in toto and with special reference to the payment of Blue Shield for anesthesia fees given by an anesthetist, the fee accruing to the hospital. There was quite a bit of discussion as to how this could be adjusted so that it would fall into the category of rightful and ethical practice. The Judicial Council has recommended at one of its meetings that the Blue Shield modify its payment procedure so as to permit the policy holder to obtain indemnity for anesthesia administered in the smaller hospitals which do not have anesthesiologists. The Reference Committee recommends that this problem be studied jointly by the Judicial Council of the Kentucky Medical Association and the Board of Directors of Kentucky Physicians Mutual for the purpose of arriving at an equitable and ethical payment of these services.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion was seconded and carried.)

The Reference Committee reviewed the remainder of the report of the Judicial Council and concurs in the remainder of this report.

Mr. Speaker, I move the adoption and implementation of this report as a whole as amended with special emphasis on the recommendation made by this committee.

(Motion seconded; carried.)

Report of the Advisory Committee to the Editor

Your committee held no meetings during the 1966-67 Associational year because no matters were referred to it for consideration and the committee itself had no recommendations to make.

We would commend to you the good work of our editors and express appreciation for their continuing interest and the contributions they are making through their work on the Journal.

Paul C. Grider, Jr., M.D., Louisville
Robert G. Overstreet, M.D., Louisville
Eugene Q. Parr, M.D., Lexington
Gerald B. Reams, M.D., Ashland
Orson P. Smith, M.D., Louisville
Frederick A. Scott, M.D., Madisonville
Blaine Lewis, Jr., M.D., Louisville
Chairman

Recommendations, Reference Committee No. 6

Report No. 18 was considered. No action on the part of the Reference Committee was required.

Mr. Speaker, I move the adoption and implementation of this portion of the report.

(Motion seconded; carried.)

Report of the Constitution and Bylaws Committee

The Committee to Study the Constitution and Bylaws held its meeting on Wednesday, June 7, and gave long and careful study to the matters referred to it for submission to the House of Delegates to change the Constitution and Bylaws of the Association.

The prime considerations before our group were referred by the Board of Trustees, which had previously during the year taken action on recommendations submitted by the Commission to Study the Reorganization of KMA. These recommendations require changes in the Constitution and Bylaws for implementation.

To assist us in our deliberations, KMA Secretary and Chairman of the Commission to Study the Reorganization of KMA, Henry B. Asman, M.D., and Mr. E. Gaines Davis, legal counsel, were in attendance at our meeting. The detailed recommendations and background material relative to the report of the Commission to Study the Reorganization of KMA submitted to the Board can be found in the report of the Chairman of the Board of Trustees.

You will note there are recommendations contained in that report requiring Bylaw changes that are not being presented to you this year. The reason for this is that we must first make some changes in our Constitution. You will recall that constitutional changes must "lay over" for one year before they can receive final action. These constitutional changes are being proposed; and if given final approval in September of 1968, will at that time be accompanied by further Bylaw changes.

Hoping to create minimal confusion, the format of our report will be to 1) present the reason for the changes in the Constitution, 2) quote the wording of the present section of the Constitution concerned, and 3) present the proposed amendment to the Constitution. This same format will be used for Bylaw changes. All recommendations were originated by the Commission to Study the Reorganization of KMA unless otherwise quoted.

AMENDMENTS TO THE CONSTITUTION

RECOMMENDATION

1. That there be only one vice president, elected from the same area of the state as the president.

2. That an alternate trustee be elected from each district to represent that district if the trustee is unable to attend the meeting of the Board.

ARTICLE V. Officers

Present Section 1: The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Proposed Section 1: The officers of this Association shall be a President, a President-elect, a Vice President, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Present Section 2: The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Proposed Section 2: The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3: No changes proposed.

Section 4: No changes proposed.

AMENDMENTS TO THE BYLAWS

RECOMMENDATION

That the Secretary and Treasurer be limited to consecutive terms of three years each.

CHAPTER IV. ELECTION OF OFFICERS

Present Section 1: The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, in so far as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice-Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Proposed Section 1: The President-Elect and the Vice Presidents shall be elected for a term of one year, the President-Elect succeeding to the Presidency at the expiration of his term as President-Elect.

The Speaker of the House of Delegates, the Vice-Speaker, the Secretary and the Treasurer shall be elected for terms of three years, but no member shall be eligible for election to more than two consecutive full terms as Secretary or Treasurer.

Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible.

No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice-Speaker of the House of Delegates, or Trustee, who has not been an active member of the Association for at least five years.

RECOMMENDATION

That unless there is unanimous consent of the House to introduce a resolution, all resolutions must be forwarded to the headquarters office seven days prior to the opening meeting of the House of Delegates; otherwise, new business would be introduced to the House of Delegates only through the Board of Trustees.

CHAPTER III. The House of Delegates

Section 1 through 7: No changes proposed.

Present Section 8: No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Proposed Section 8: No resolution shall, without unanimous consent, be introduced in the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven (7) days prior to its introduction. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Sections 9 through 18: No changes proposed.

RECOMMENDATION

1. That the council system be discontinued (as discussed in the report of the Chairman of the Board of Trustees) and that committees be grouped into areas of activity as follows: Annual Meeting activities, medical education and hospitals, legislative activities, medical services, communications and public service, and governmental medical services.

2. That Chapter VIII of the Bylaws be deleted and rewritten so that only the appointing authority for commissions and committees would be outlined in the Bylaws and not specific duties of committees and other matters involving frequent Bylaw changes.

CHAPTER VIII. Standing Committees and Councils

Present Chapter VIII. Standing Committees and Councils.

Proposed Chapter VIII. Committees and Commissions

Present Section 1: Delete entire present section.

Proposed Section 1: The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Present Section 2: Delete entire present section.

Proposed Section 2: The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Present Section 3: Delete entire present section.

Proposed Section 3: The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary, ad hoc, committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Present Section 4: Delete entire present section.

Proposed Section 4: No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

Present Sections 5 through 18: Delete entire present sections.

RECOMMENDATION

The Judicial Council has submitted a recommendation to clarify Chapter VII of the Bylaws.

CHAPTER VII. Discipline, The Judicial Council

Present Section 1: No change proposed.

Present Section 2, first paragraph: No change proposed.

Present Section 2, second paragraph: At the request of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Proposed Section 2, second paragraph: Upon the complaint of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent and a representative of the

Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

Proposed Section 2, third paragraph: In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

COMMITTEE TO STUDY THE CONSTITUTION AND BYLAWS
John S. Baughman, III, M.D., Harrodsburg
Matthew C. Darnell, Jr., M.D., Lexington
Tom M. Marshall, M.D., Louisville
James G. Sills, M.D., Hardinsburg
W. Bruce Hamilton, M.D., Shepherdsville, Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 considered carefully the report of the Constitution and Bylaws Committee and wishes to commend both the Constitution and Bylaws Committee and the Special Study Commission which has made the recommendations that are to be implemented by this report.

Many members of the House of Delegates appeared before Reference Committee No. 6 and made suggestions concerning the proposed amendments to the Constitution and to the Bylaws. After considering these suggestions, the Reference Committee wishes to propose two changes in the report of the Committee to Study the Constitution and Bylaws.

Under the Proposed Section 8, page 4 of Report No. 19, the Reference Committee wishes to recommend the following substitute wording for the Proposed Section 8, to wit:

No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Mr. Speaker, I move the adoption and implementation of this portion of the report as amended. (Motion seconded; carried).

The second change which we propose under the Proposed Section 2 on page 5 of Report No. 19 is in the first sentence of this section as submitted which reads as follows:

The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations from the floor.

We recommend deletion of the last three words "from the floor" and the sentence shall then read as follows:

The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations.

Mr. Speaker, I move the adoption and implementation of the Proposed Section 2 as amended. (Motion seconded; carried.)

The Reference Committee with these two changes recommends the adoption and implementation of the report of the Constitution and Bylaws Committee as submitted.

Mr. Speaker, I move the adoption and implementation of Report No. 19 as a whole as amended.
(Motion seconded; carried.)

Report Of The Insurance Review Board

The Insurance Review Board has been in existence for four years and has as its function to help control abuses of insurance and prepayment funds, whether committed by physicians, utilizers of the services, or by the insurance and prepayment organization.

The members of the Insurance Review Board have not found it necessary to conduct a formal meeting this year as no major problems have been referred to us for consideration.

INSURANCE REVIEW BOARD
Bernard J. Baute, M.D., Lebanon
Harvey Chenault, M.D., Lexington
David M. Cox, M.D., Louisville
John L. Dixon, M.D., Owensboro
Paul H. Klingenberg, M.D., South Fort Mitchell
William C. Mitchell, M.D., Louisville, Chancellor

Recommendations, Reference Committee No. 6

The Report of the Insurance Review Board was reviewed and it is noted that the members of the Insurance Review Board did not find it necessary to conduct a formal meeting this year as no major problems were referred to it.

Mr. Speaker, I move the adoption and implementation of this report as a whole.
(Motion was seconded and carried.)

Report Of The Committee On Arrangements For The Interim Meeting

The Interim Meeting program committee for the 1967 session at Ken-Bar Inn, Gilbertsville, Kentucky, met on October 26, 1966, at the Holiday Inn at Elizabethtown.

Before considering the 1967 program, the committee reviewed the experience at Cumberland Falls with the new format for the meeting, which was authorized by the Board of Trustees.

The committee was briefed on the facilities available at Ken-Bar, and it was apparent there were an adequate number of meeting rooms, bedrooms, and other facilities for this meeting.

Plans for the promotion of attendance at the meeting were carefully discussed and agreed on with the Woman's Auxiliary lending appropriate support. The committee then went about the business of planning the three sessions, which are the dinner meeting, the morning general session and the closing luncheon session.

The general theme for the program was selected, speakers were agreed upon, and alternate speakers were chosen in case some of the original group were not available.

Your committee appreciates the cooperation of the Woman's Auxiliary and the Marshall County Medical Society in making this program a success.

COMMITTEE ON ARRANGEMENTS FOR THE INTERIM MEETING
George F. Brockman, M.D., Greenville
Rex E. Hayes, M.D., Glasgow
Mrs. Raymond E. Jones, Louisville
Joseph R. Miller, M.D., Benton
Carroll W. Traylor, M.D., Calvert City
Robert E. Pennington, M.D., London, Chairman

Recommendations, Reference Committee No. 6

The Reference Committee reviewed the report of the Committee on Arrangements for the Interim Meeting. We wish to commend the Committee on Arrangements for the excellent work which was done in setting up the program and arrangements for the 1967 meeting. The Chairman of your Reference Committee wishes to call attention to the fact that the Interim Meeting for 1968 is scheduled to be held in the Covington area and on behalf of the Campbell-Kenton and Boone County Medical Societies wishes to extend a cordial invitation to all to attend this meeting.

Mr. Speaker, I move the adoption and implementation of this portion of the report.

(Motion seconded; carried.)

Supplemental Report A Report Of The Chairman Of The Board Of Trustees

(We pointed out earlier that the report of the KMA Commission to Study the Reorganization was in two parts. We have already reported on Part A—this supplemental report covers Part B.)

Perhaps it would be appropriate to remind the members of the House that the membership of the Commission to Study the Reorganization of KMA was made up of 14 highly qualified physicians. Because of their broad experience at all levels of medicine, their demonstrated ability at solving problems, and loyalty to the profession, the members of the Board of Trustees felt that the Commission's recommendations commanded the most thorough consideration.

A voluminous amount of research as to what was taking place in other states and the AMA, in-depth discussions by the Commission, both in groups, subcommittees and the Commission as a whole, produced the following recommendations:

Except for the last part of this supplemental report relating to redistricting, all of the Commission's recommendations in part B approved by the Board have been passed on to the KMA Bylaws Committee with the request that this committee formalize these recommendations for the consideration by the House of Delegates. You will find these recommendations in the KMA Bylaws Committee Report No. 19.

Until we reach the final recommendation on redistricting, this part of the report will be in narrative form which is intended to give brief background information on the recommendations of Report No. 19. Our comments will be keyed to that report.

One of the general premises of the Commission was that the size of the Board of Trustees was too large. They also felt that one way of reducing the size would be to eliminate two of the three vice presidents. It was also felt that three vice presidents served no useful purpose.

It was decided to recommend that there be one vice president elected from the same area as the president and that he be the second ranking officer of the Association. The Board accepted this recommendation and the Bylaws Committee has formalized it in Report No. 19, page 2, entitled "Proposed Section 1."

The Commission recommended that the terms of the secretary and treasurer should be limited to two consecutive terms of three years each. This was also approved by the Board and the proposed Bylaw implementing this will also be found on page 2 of Report No. 19.

The problem caused by last minute introduction of resolutions at the first meeting of the House of Delegates was reviewed in detail. Members of the Commission felt that in order to allow an adequate amount of time for the duplication, distribution and study of these resolutions, the deadline for their introduction should be made at least a week before the House meets. The Board of Trustees approved this recommendation and the proposed implementation is found in the Bylaws Committee Report No. 19, page 4.

The review of the committee and council structure of the Association perhaps consumed more time, thought, and effort than any other one part of the Commission's report. Being eager to develop a committee structure that would be flexible yet provide strength and immediacy of action, the Commission gave much thought to pruning the out-moded, ineffectual, and non-essential committees and programs of the Association. The Commission was impressed by a recommendation made by the chairman of one of the councils, suggesting the discontinuance of the present council and committee system in the Association. Careful study produced the following arguments supporting this recommendation:

1. The council system stifles committee work, sometimes requiring months for recommendations to go through channels and reach the Executive Committee or Board of Trustees for action.

2. Seldom do the councils initiate action on their own, but merely act on committee recommendations. Even though they may be assigned a "general field" they just do not initiate new projects and find nothing new to say.

3. Council members feel that the council meets just to listen to what the committees are doing. The committee chairmen aren't interested in coming to the council meeting and the council members are not knowledgeable—and for that reason not particularly interested—in the details of committee activity.

4. For some of the reasons already mentioned, the councils have difficulty in obtaining a quorum for their meetings.

5. The council system is good in theory but is just not operating now in a practical manner.

(Members of the House of Delegates will be interested to know that if you accept this recommendation, the Commission went on to propose a new committee system which would not abandon any of the present programs of value but would combine and contribute to a more workable structure.)

The Board of Trustees unanimously accepted the Commission's recommendation relating to councils and asked the Bylaws Committee to draft formal recommendations implementing these changes. The work of the Bylaws Committee in the proposed implementation of this recommendation will be found on page 5, Report No. 19, under the title "Chapter 8, Committees and Councils."

PROPOSAL FOR REDUCING THE NUMBER OF TRUSTEE DISTRICTS

Members of the Commission carefully reviewed the duties, functions and operations of the KMA Board of Trustees. There were two matters that particularly interested the members of the Commission in this connection. One was the broad variance in the number if KMA members in the various districts. For instance, one district has only 60 members, while the most populous has 801. Eight of 15 districts have fewer than 100. A second observation the Commission made was that the Board of Trustees has too many people on it and therefore tends to be unwieldy.

At its April meeting, the Board of Trustees accepted in principle the recommendation that the number of trustees be reduced and that there should be less disparity in the number of members per trustee. The Board asked the Executive Committee to make a recommendation to the full meeting of the Board in August on how these changes might be accomplished. The Executive Committee met late in July. A considerable amount of material had been sent to each member of the committee prior to the meeting for review.

After full discussion, the Executive Committee voted to recommend to the Board that the number of districts be reduced to seven and that the geo-

graphical boundaries should be the same as the seven Congressional Districts in Kentucky, with the exception that the entire county of Jefferson would make up the Third District. In addition, it was proposed that the third district with the membership of 801 should have three trustees and that the sixth district with 503 should have two trustees, making a total of 10, which corresponded to the recommendation of the Commission.

It was pointed out that under this system, the maximum number of members for any one trustee would be 267 and the minimum would be 174.

The Executive Committee pointed out the principal advantages of using such a system which included:

1. the development of a greater Congressional District consciousness;
2. facilitating legislative action at the national level;
3. providing greater efficiency for the Key Man System; and
4. more efficient and less costly KMA mailing lists.

A recommendation from the Commission that consideration be given to the development of multi-county medical societies providing for greater efficiency in the operation of the Association at the local level was given full consideration. It was decided, however, that this matter should await the decision on redistricting of the trustee districts.

If the proposal for the redistricting of the Association, just explained, is adopted, then the Commission and the Board would propose that the state be divided into four sections for the purpose of naming presidents. At present, the presidency is rotated between the Central (Jefferson County), the Western, and the Eastern Districts. There are, however, no firm lines to divide these districts.

There are approximately 800 members in Jefferson County. The division of the remainder of the state into Eastern and Western sections with approximately equal physician population in each, might be accomplished by drawing a line from Louisville south and east which would include Pulaski and Whitley counties in the Western District. This would obviously cause a great deal of confusion if such a delineation were undertaken. The Commission recommended that the presidency be rotated between four regions instead of three. This would mean that the first and second Congressional Districts would comprise the Western region, that Jefferson County or the Third Congressional District would provide the Central region; that the fourth and sixth Congressional Districts would provide the Northcentral region; and that the fifth and seventh Congressional Districts make up the Southeastern region. This would mean, for instance, that the third district (Jefferson County) would have the presidency once every four years.

Rex E. Hayes, M.D., Chairman
Board of Trustees

Recommendations, Reference Committee No. 6

A major portion of the time used by Reference Committee No. 6 was devoted to consideration of Supplemental Report A of the Report of the Chairman of the Board of Trustees to the House of Delegates.

An extensive discussion on this report was held by many members of the House of Delegates and the Reference Committee wishes to thank all of those who participated.

Most of this discussion concerned the proposal for redistricting the number of trustee districts. Many valid suggestions both in favor of and opposed to the proposal for redistricting the trustee districts were brought forth.

In view of the fact that so many dedicated and knowledgable members of the House of Delegates expressed opposition to the changes proposed, Reference Committee No. 6 recommends that the proposal for redistricting the number of trustee districts not be approved at this time and further recommends that this matter be referred back to the Board of Trustees for further consideration. Your Reference Committee also recommends that the proposal for redistricting the Presidential Districts be referred back to the Board for further study at this time.

Mr. Speaker, I move the adoption and implementation of this portion of the report as amended.

(Motion seconded.)

During discussion, a motion was made, seconded and passed to amend Reference Committee Report No. 5, Supplemental Report A of the Board of Trustees as follows: that the words "details of the" be added after the phrase "members of the House of Delegates expressed opposition to the"; and that the following be added at the end of the paragraph beginning "In view of the fact that so many dedicated and knowledgable members": "It is hereby noted, however, that the House of Delegates of the KMA favors the concept of redistricting as regards both Trustee and Presidential districts. It is also noted that the House of Delegates further requests the Board of Trustees to revise this redistricting proposal, and to present the revised proposal at such a time as will allow action on this proposal at the 1968 meeting of the House of Delegates".

The original motion, as amended, was restated, as follows:

"In view of the fact that so many dedicated and knowledgeable members of the House of Delegates expressed opposition to the *details of the* changes proposed, Reference Committee No. 6 recommends that the proposal for redistricting the number of trustee districts not be approved at this time and further recommends that this matter be referred back to the Board of Trustees for further consideration. Your Reference Committee also recommends that the proposal for redistricting the Presidential Districts be referred back to the Board for further study at this time. *It is hereby noted, however, that the House of Delegates of the KMA favors the concept of redistricting as regards both Trustee and Presidential districts. It is also noted that the House of Delegates further requests the Board of Trustees to revise this redistricting proposal, and to present the revised proposal at such a time as will allow action on this proposal at the 1968 meeting of the House of Delegates.*"

The question was called for, and upon being put to a vote the amended motion was adopted.

The remainder of Supplemental Report A was considered by Reference Committee No. 6. The portion concerning the election of one vice president has been covered under Report No. 19 and no further action by the Reference Committee on this is considered necessary. The same applies to limitation of the terms of the secretary and treasurer to two consecutive terms of three years each and to the recommendation that resolutions must be in the hands of the office staff one week prior to the meeting.

Your Reference Committee also considered the recommendation that the council and committee structure be revised and concurs in the recommendation that the present council structure be discontinued. It wishes to call attention to the fact that the committee structure is under continuing review by the Board of Trustees and that the new committee structure will be made known to the membership of the Kentucky Medical Association as soon as it has been completed by the Board of Trustees.

Mr. Speaker, I move the adoption and implementation of Supplemental Report A as a whole as amended.

(Motion seconded; carried.)

Resolution D

Muhlenberg County Medical Society

Be it remembered that at its regular meeting on Monday, August 7, 1967, the following resolution was adopted by the Muhlenberg County Medical Society for presentation to the 1967 KMA House of Delegates:

WHEREAS the American Medical Association is the national voice of medicine, organized and unorganized; and

WHEREAS the American Medical Association has expended great sums of money to present medicine's viewpoint in attempting to limit government interference with the traditional physician practice and relationship; and

WHEREAS it has exerted and continues to exert the only appreciable influence on federal government policies in the field of governmental health services; and

WHEREAS the purposes for which the Kentucky Medical Association was organized, namely, "to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; *the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests;* the protection of the members thereof against unjust assaults upon their professional care; skill or integrity; *and to the enlightenment and direction of public opinion in regard to the great problem of state medicine* so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life", may well be subverted or rendered incapable of performance if further encroachments by federal and state government are enacted into law;

NOW THEREFORE, BE IT RESOLVED by the House of Delegates of the Kentucky Medical Association that membership in the American Medical Association be determined to be essential to the well-being of this Association and that it henceforth be required as a condition of membership in this Association, that each member of this Association also be a member in good standing of the American Medical Association.

Recommendations, Reference Committee No. 6

Resolution D. AMA Membership, submitted by Muhlenberg County Medical Society was considered. The Reference Committee gave every opportunity to all interested members of the House of Delegates to present and express their views. Strong opinions were held both favoring and opposing Resolution D. After careful consideration of the resolution, the members of Reference Committee No. 6 unanimously approved the resolution and favored its adoption.

Mr. Speaker, I move the adoption and implementation of Resolution D.

(Motion was seconded. Following discussion, the motion was defeated.)

Resolution Q

Fayette County Medical Society Delegates

WHEREAS, American Medical Association policy encourages acceptance of qualified osteopaths as members of state associations, and

WHEREAS, Kentucky Medical Association bylaws, Chapter 1, Section 2, subsection (a) limits membership only to medical doctors,

NOW THEREFORE BE IT RESOLVED that the phrase "or osteopathy" be inserted in this bylaw to follow the phrase "doctor of medicine."

Recommendations, Reference Committee No. 6

Resolution Q, Qualified Osteopaths as Members of State Medical Association, submitted by Fayette County Medical Society, was considered. In introducing this resolution, Fayette County Medical Society has called attention to the fact that the American Medical Association's policy encourages acceptance of qualified osteopaths as members of state associations; and has recommended that Chapter I, Section 2, sub-section A of Kentucky Medical Association Bylaws be changed so that membership rather than being limited to "doctor of medicine" shall now read "doctor of medicine or osteopathy".

Mr. Speaker, I move the adoption and implementation of Resolution Q.

(Seconded. Defeated.)

Mr. Speaker, I move the adoption and implementation of Report of Reference Committee No. 6 as a whole as amended.

(Motion seconded and carried.)

Mr. Speaker, I wish to take this opportunity to express my sincere appreciation for the work of the other members of this committee and to the members of the House of Delegates who appeared before the Reference Committee to express their views.

The Chairman also wishes to thank Mrs. Wittig for her assistance in the preparation of this report.

REFERENCE COMMITTEE NO. 6
W. Vinson Pierce, M.D., Covington, Chairman
John M. Baird, M.D., Danville
N. Lewis Bosworth, M.D., Lexington
Robert L. McClendon, M.D., Louisville
Dixie Snider, M.D., Springfield

REFERENCE COMMITTEE NO. 7

Harvey A. Page, M.D., Chairman

Miscellaneous Reports

Reference Committee No. 7 considered the following reports:

22. Report of McDowell House Board of Managers
23. Report of Memorials Commission
26. Report of Board of Trustees, Rural Kentucky Medical Scholarship Fund
27. Report of KMA Representative to Conference of Presidents and other Officers of State Medical Associations

Report Of The McDowell House Board Of Managers

The Board of Managers have met at the McDowell House four times during the past year, August 24, 1966, December 14, 1966, April 5, 1967, and June 28, 1967. The physical and financial state of the house has been examined repeatedly. The house is in its best condition in our time. The interior and exterior have been necessarily painted, and numerous minor repairs have been made. These have added much to the beauty of the house. These necessary expenses, repairs, and hostesses' salaries have caused the Board to have exceeded its budget by some $200.00, but fortunately some of the expenses are not of an annual nature.

The income from paid admissions to the house was $1,077.60 from July 1, 1965 to July 1, 1966, and $1,326.26 from July 1, 1966 to July 1, 1967.

An exhibit of the McDowell House was arranged for the Kentucky Medical Association, the Kentucky Academy of General Practice, and the District V meeting of the American College of Obstetricians and Gynecologists in Louisville during this fiscal year. A separate type of exhibit, upon special request, has been prepared and is on view in the new office building of the American College of Surgeons in Chicago, to remain there from June 1 through August 31, 1967. Mr. George Grider, Board Member and President of the American Pharmaceutical Association, and Dr. Franke presented another exhibit of the house at the Annual Meeting of this organization in Las Vegas on April 10, 1967.

The Woman's Auxiliary continues to contribute an invaluable service to the house. A compact modern

kitchenette has been installed and hidden in an antique cabinet, from contributions from the Woman's Auxiliary. In addition to new furnishings and the replacement of certain antiques, the decor and quality of the house have continued to improve. Two oil paintings of Doctor McDowell's brother and son-in-law have been repaired and refurbished at a cost of $700.00.

During the year, many groups and organizations visited the house. Among them was the Blue Grass Trust, a historic preservation society from Lexington. This organization officially expressed great appreciation of the quality of the restoration of the McDowell House.

The Board has had prepared and printed invitations to membership in the McDowell House, at a cost of $600.00. One thousand each will be mailed to specialists in Obstetrics and Gynecology in New York, Illinois, and California. These will be addressed and mailed by the Boyle County Medical Auxiliary. If the procedure seems financially feasible, it will be extended to many organizations, both professional and lay, over the country. The results of the sampling requests may indicate the feasibility of the present format or indicate that a different approach is necessary.

In the past year, contributions have been received from the District V, College of Obstetricians and Gynecologists, Kentucky Surgical Society, Southeastern Surgical Association, Southern Surgical Association and the Central Association of Obstetricians and Gynecologists. These latter contributions are of an annual nature and at any time may not be renewed. The Board of Managers is attempting to find a different method of financing the house.

MCDOWELL HOUSE BOARD OF MANAGERS
Laman A. Gray, M.D., Chairman
Robert C. Bateman, M.D.
B. B. Baughman, M.D.
Mr. Sterling Coke
Dr. Norman Franke
E. M. Howard, M.D.
Mr. Enos Swaine
Mr. James L. Cogan
Mr. George Grider
Richard H. Segnitz, M.D.

Recommendations, Reference Committee No. 7

The Report of the McDowell House Board of Managers was reviewed and studied by the Committee. We feel that this is a good report and would like to compliment the Board of Managers for having lost just $200.00 during the 1966-67 year.

Mr. Speaker, I move the adoption of the report and the implementation of the report.

(Motion seconded and carried)

Report Of The Memorials Commission

The Memorials Commission met twice during this past year, 23 November 1966 and 18 May 1967 at the KMA Headquarters.

We are pleased to report that a plaque indicating the memorials to past presidents of the KMA has been purchased and engraved with the names of those men who had been so honored. This plaque now hangs in the President's Office at the KMA Headquarters. The furnishings in the Board Room except two chairs and the settee, have been purchased by members of our KMA and presented to the members.

In the process of re-examining our building for storage space, a number of interesting journal supplements, old society records, and several manuscript account books of the Society were discovered. These have been placed in the Library Museum. Several books were also uncovered in this process and they, too, have been placed in the Library. Duplicates of published material relating to Ephriam McDowell have been sent to the McDowell House for possible use.

Since our last annual report, we have acquired a copy of the Constitution and Bylaws of KMA for the year 1902, a replica of the McDowell House, and a gavel that was made of wood removed from the McDowell House during restoration.

The Commission is contemplating commissioning a copy of the famous family oil portrait of our first president, William Loftus Sutton, M.D., for the President's Office.

There still remains much to do in publicizing the Memorials Commission's interest in the acquisition of early 19th century surgical and diagnostic instruments, copies of contemporary medical and surgical texts used prior to 1850 in this part of our then New West, and copies of the transactions of the KMA for the Library Museum.

The Commission is greatly saddened by the sudden death of one of our enthusiastic members, G. Y. Graves, M.D. of Bowling Green, just prior to our May, 1967 meeting. Doctor Graves gave of his time and talents to the Memorials Commission. He was enthusiastic in his support of the activities and objectives of the Commission and his absence will be strongly felt.

We look forward to some publications in the KMA Journal during the coming year to apprise our members of the activities and thoughts of the Memorials Commission.

MEMORIALS COMMISSION
J. Duffy Hancock, M.D., Louisville
Francis Massie, M.D., Lexington
J. M. Stevenson, M.D., Brooksville
Eugene H. Conner, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

The Report of the Memorials Commission was reviewed, and the Committee would like to compliment the Commission for the work that it has done during the year 1966-67.

Mr. Speaker, I move the adoption of this report and the implementation of the report.

(Motion seconded and carried.)

Report Of The Rural Kentucky Medical Scholarship Fund

The Fund, which was established as a means of providing a better distribution of physicians in rural Kentucky, has now been in operation for over 20 years.

In retrospect, the records show loans to 290 recipients with 123 now in practice in 80 counties of Kentucky with 12 serving in critical counties. There are 36 recipients now in the Armed Services, including one in the Space Program, 22 interning, 29 in specialty training programs, and 37 in medical schools, including the 11 new applicants approved this year. Three previous recipients now serve as members of the KMA Board of Trustees.

Approximately 15% of the original applicants either did not complete their medical education, are deceased, or moved to other states after fulfilling their obligation to the Fund.

The Fund since its beginning, using the revolving amount of monies available, has loaned over $810,000. There are now outstanding over 400 loans to 156 borrowers for a total amount in excess of $428,000.

All loans and contracts are processed at the KMA office. Progress reports are secured on students in medical school, and contact is maintained with interns, recipients in the Armed Services, those in specialty training and past recipients in practice.

Loans are available to residents of Kentucky who have been admitted to an accredited medical school,

and who will agree to practice in rural Kentucky for one year for each loan received. Currently, the Fund will lend $2,500 per year to applicants who agree to practice in counties listed as "critically in need of physicians" or in the Kentucky Public Health Service in an approved area. One year's loan is waived for each year of such practice.

Regular loans of up to $1,500 per year at an interest rate of 2% to maturity permit practice in over 100 rural counties in the state. Should a student later decide to practice in a "critical" county, one year's loan will be forgiven for each year of practice. One-half a year's loan for each year of practice in a semi-critical area will be forgiven.

The ten critical counties selected for 1967-68 on the basis of information supplied by the Kentucky Medical Association and the State Board of Health are Knott, Jackson, Crittenden, Metcalfe, Powell, Meade, Estill, McCreary, Rockcastle and Leslie. Semi-critical areas selected are Owsley-Breathitt, Magoffin-Wolfe, Bracken-Robertson, Clinton-Cumberland, Butler-Edmonson, Lewis-Carter, Lincoln, Martin, Owen and Todd.

As an incentive to physicians entering practice for the first time, the Fund will lend $2,000, forgiving $500 per year in a critical county and $250 per year in a semi-critical area.

This year the Board approved a new team concept whereby the Fund will grant a $2,000 loan to a two-physician team planning to establish practice in approved areas where the ratio is less than one physician to 6,000 inhabitants. The forgiveness features of the critical or semi-critical areas also apply to this program. The Fund would enter into an individual contract with each physician, and would not become involved in the team contract.

The Board of Trustees is especially appreciative of the continued interest and support of Governor Edward T. Breathitt, Health Commissioner Russell E. Teague, M.D., and the Kentucky General Assembly.

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND
C. C. Howard, M.D., Glasgow
Chairman, Board of Trustees

Recommendations, Reference Committee No. 7

This report was critically reviewed, and the Committee feels the Scholarship Fund continues to serve a very useful and worthwhile purpose.

Mr. Speaker, I move the adoption of the report and the implementation of the report.

(Motion seconded and carried.)

Report Of The Conference Of Presidents And Other Officers Of The State Medical Associations

The 22nd Annual Meeting of the Conference of Presidents and Officers of State Medical Associations was held June 17 in Hadden Hall, Atlantic City.

The meeting was called to order at 2:00 p.m. and a most informative address was delivered by the President-Elect of the Conference, Durward Hall, M.D., congressman from Missouri.

Paul Harvey, nationally-known columnist and broadcaster, presented an interesting and frank address that provided much discussion by the conference participants.

The final session of the day was a blue ribbon panel of outstanding correspondents, reporters, and economists discussing the subject "Who Really Runs Washington."

Adjournment of the conference came at 5:00 p.m.

Robert E. Pennington, M.D.
President

Recommendations, Reference Committee No. 7

This report was reviewed, and it was noted that a worthwhile program was presented to the participants.

Mr. Speaker, I move the adoption of the report and the implementation of the report.

(Motion seconded; carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 7 as a whole.

(Motion seconded; carried.)

I would like to express my appreciation to the members of Reference Committee No. 7 for their taking part in the work of this committee.

REFERENCE COMMITTEE NO.7
Harvey A. Page, M.D., Pikeville,
Chairman
James Holbrook, M.D., Prestonsburg
James G. Sills, M.D., Hardinsburg
Loman C. Trover, M.D., Madisonville
Donald Varga, M.D., Louisville

Unfinished Business

Doctor Greathouse recognized Rex E. Hayes, M.D., Chairman of the Board of Trustees, for the final report of that group. The report follows:

"The KMA Bylaws provide that the Judicial Council be composed of five members. Four of these members are to be elected by the House of Delegates with terms staggered so that one member will be elected each year. The KMA Secretary, who is elected by the House, automatically serves as a member of the Council.

"According to the Bylaws, Chapter VII, Section 1, 'to be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.'

"The Bylaws provide that the Board of Trustees shall nominate at least one candidate for each vacancy and that additional nominations may be made from the floor.

"The term of Clyde C. Sparks, M.D., Ashland, expires with this meeting. The Board of Trustees has unanimously voted to nominate Doctor Sparks to succeed himself for a four year term."

Doctor Hayes moved the adoption of this report. Motion was seconded and carried.

Election Of Officers

The Speaker called for the report of the Nominating Committee which was presented by its Chairman, Robert L. McClendon, M.D., Louisville. Doctor McClendon read the following list of nominations for the positions as noted:

President-Elect (Central)—	Henry B. Asman, M.D., Louisville
Vice-Presidents	
Central	Glenn W. Bryant, M.D., Louisville
Eastern	J. Sankey Williams, M.D., Nicholasville
Western	Luther M. Wilson, Jr., M.D., Bowling Green
AMA Delegate	John C. Quertermous, M.D., Murray
AMA Alternate Delegate	Daryl P. Harvey, M.D., Glasgow
AMA Delegate	Charles C. Rutledge, M.D., Hazard
AMA Alternate Delegate	David B. Stevens, M.D., Lexington
Secretary	S. Randolph Scheen, M.D., Louisville

After each nomination was presented, the Speaker called for nominations from the floor. As no nominations were received, it was moved and seconded that the nominees be elected. Motion carried.

The following nominations for the offices of trustees were submitted by Doctor McClendon:

Second District	William W. Hall, M.D., Owensboro
Seventh District	Donald Chatham, M.D., Shelbyville
Ninth District	J. Campbell Cantrill, M.D., Georgetown
Tenth District	Andrew M. Moore, M.D., Lexington
Thirteenth District	Walter L. Cawood, M.D., Ashland

The same procedure followed in the election of the general officers was followed in electing the trustees. Since there were no nominations from the floor, the above-named nominees were elected.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

Because the list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was not available a motion was made and seconded that the KMA Board of Trustees be instructed to review the list and make any desired additions to it. Motion carried.

Election Of 1968 Nominating Committee

Elected to serve at the 1968 Annual Meeting as the Nominating Committee were the following:

Ralph M. Denham, M.D., Louisville
Meredith J. Evans, M.D., Middlesboro
David A. Hull, M.D., Lexington
W. Faxon Payne, M.D., Hopkinsville
David B. Stevens, M.D., Lexington

Following this action, Doctor Greathouse recognized Walter I. Hume, Jr., M.D., Louisville, who stated that since the House has gone on record as favoring redistricting, he wanted to present a change in the wording of Article VIII of the Constitution from a statement which reads: "The Board of Trustees shall be composed of one trustee from each district" to say "shall be composed of one or more trustees from each district". He further stated that this proposal is not being presented for a vote or any action on the part of the House at this time. It is simply being presented as a matter of record that it was presented to the 1967 meeting of the House of Delegates so that it will be in order to vote on next year.

As he was escorted to the podium, Doctor Asman, the new president-elect, received a standing ovation. Upon arriving at the podium of the Speaker's table, Doctor Asman spoke briefly, thanking the members of the House for placing their confidence in him by electing him to this position.

George F. Brockman, M.D., Greenville, was installed as president with the oath of office being administered by the Chairman of the Board of Trustees, Rex E. Hayes, M.D. President Brockman then presented the Past President's Plaque to Doctor Pennington, the retiring president.

Members of the House of Delegates then heard brief comments from the newly installed president.

Doctor Pennington invited all members and guests present at the House to a reception in his suite immediately after adjournment.

The second session of the 1967 House of Delegates was adjourned at 10:50 p.m.

ORGANIZATION SECTION

KMA Interim Meeting Planned April 17-18 in Covington

The 1968 KMA Interim Meeting plans are well underway, according to George F. Brockman, M.D., Greenville, KMA president. The meeting will be held at the Statler Hilton Motel (formerly the Lamplighter) in Covington, April 17 and 18.

Discussions of Title XIX, usual and customary fees and other matters of intense concern have been planned by the program committee and speakers are being contacted, Doctor Brockman said.

Other features planned at the time of the Interim Meeting include an Orientation Program and meetings of the KMA Board of Trustees and the Woman's Auxiliary Board.

The Statler Hilton Motel, located just 10 minutes from the Greater Cincinnati Airport, has excellent facilities for meetings. Doctor Brockman urges all physicians to begin making plans now to attend what promises to be an outstanding program.

Dr. Brockman Speaks at Meetings Of Two Trustee Districts

George F. Brockman, M.D., Greenville, KMA president, was the featured speaker at a meeting of the Ninth Trustee District November 9 and was scheduled to speak at the December 7 meeting of the Fourth Trustee District at press time.

The Ninth Trustee District, arranged by trustee J. Campbell Cantrill, M.D., Georgetown, met at the Stockyards Restaurant near Paris. The Fourth District was scheduled to meet at the Holiday Inn, Elizabethtown, according to trustee Henry S. Spalding M.D.

Fred Rainey, M.D., Elizabethtown, chairman of the Committee on Legislative Activities for State Affairs, also appeared on the program of the Ninth Trustee District and was scheduled to speak at the Fourth Trustee District meeting.

U of L Holds Ground Breaking For Medical-Dental Complex

In spite of a freeze on federal funds needed to begin construction of the $25 million University of Louisville Medical-Dental Complex, ground breaking ceremonies were held October 27 by the University.

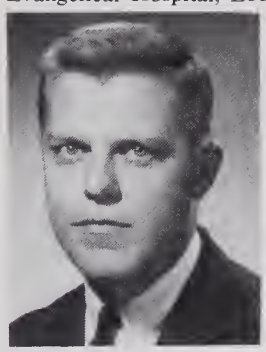
However, the freeze on funds ended November 16 and construction was scheduled to begin at an early date.

Donn L. Smith, M.D., dean of the School of Medicine, and Raymond Myers, D.D.S., dean of the School of Dentistry, broke ground for the complex. Speeches were given by David Cox, M.D., the medical school's Alumni Association president, and George Nevitt, D.D.S., president of the Dental Alumni. Doctor Nevitt traveled from San Francisco to attend the ceremonies.

Russell E. Teague, M.D., state health commissioner, represented Gov. Edward T. Breathitt who was unable to attend. Doctor Teague also spoke at the ceremony.

Methodist Hospital Schedules Annual Postgraduate Day

The Third Annual Postgraduate Day at Methodist Evangelical Hospital, Louisville, will be held January 17 in the hospital's conference room, according to Charles C. Smith, Jr., M.D., program chairman.



Doctor Meador

The theme of the postgraduate program will be "Unusual Manifestations of Common Diseases." The conference is sponsored by the Methodist Evangelical Hospital and the University of Louisville School of Medicine.

Clifton K. Meador, M.D., professor of medicine at the University of Alabama, will be the guest speaker at the meeting. Doctor Meador will give two talks entitled "The Extra Pulmonary Manifestations of Bronchogenic Tumors" and "Non-disease—The Problem of Over Diagnosis".

KMA Woman's Auxiliary Holds Annual Fall Conference

A discussion of the Volunteer Friendly Visitors Training Course and a membership skit called "What Makes Mary Join" were the highlights of the annual Fall Conference of the Woman's Auxiliary to KMA November 14.

More than 30 Auxiliary members attended the conference held at the KMA Headquarters Office, according to Mrs. Charles C. Kissinger, Henderson, Auxiliary president, who presided over the afternoon session. Mrs. A. S. Holmes, Corbin, president-elect, presided over the morning session.

The Volunteer Friendly Visitors Training Course, developed by Mrs. Virgil Forester, Oklahoma City,

national chairman, was discussed by Mrs. Kissinger and Mrs. William McBeath, Lexington. The course is one of the Auxiliary's primary projects this year.

Other matters discussed at the meeting included reports on the Conference of Presidents and Presidents-Elect held in Chicago, October 8-11, and the Southern Regional Workshop in Atlanta, October 19-20.

Ky. Nurses Assn. Building Dedicated October 19

The new building for the Kentucky Nurses Association headquarters office at 1400 South First Street in Louisville was dedicated October 19 during the KNA Annual Convention.

Wilson W. Wyatt, Louisville, former lieutenant governor of Kentucky, was the featured speaker during the ceremonies. He was introduced by Mrs. Marjorie B. Glaser, KNA president.

Others participating in the dedication included Mrs. Nadine Turner, immediate past president of KNA, and Miss Nelle B. Weller, KNA executive director.

Dr. Haynes To Speak in Texas

Douglas M. Haynes, M.D., Louisville, professor and chairman of the Department of Obstetrics and Gynecology at the University of Louisville School of Medicine, will be a featured speaker at the Annual Session of the International Medical Assembly of Southwest Texas in San Antonio, January 29, 30 and 31.

Dr. Hall Elected Board Member Of Ky. Physicians Mutual

William W. Hall, M.D., Owensboro, was recently elected a member of the Board of Directors of Kentucky Physicians Mutual, the Blue Shield Plan for Kentucky.

Doctor Hall succeeds the late Thomas O. Meredith, M.D., Harrodsburg, who was one of the founders of the Blue Shield Plan in Kentucky.

In addition to serving as insurance editor of the Journal of KMA, Doctor Hall is active in the Daviess County Medical Society and has been serving as an alternate delegate to the AMA.

At the 1967 KMA Annual Meeting, he was elected to the office of trustee from the Second District.

Redistricting KMA Not An Issue Says Jeff. Co. Chairman

At the 1967 meeting of the KMA House of Delegates there was considerable discussion of a recommendation originally proposed by the Committee To Study the Reorganization of KMA.

It has been suggested that we carry the following statement made by Walter I. Hume Jr., M.D., chairman of the Jefferson County Medical Society delegation to KMA, which appeared in the November issue of the Jefferson County Medical Society Bulletin:

"The issue of redistricting is, I believe, at present dead, for all practical purposes. It would worry other delegates and divide the KMA—something none of us want."



Building dedication ceremonies were held October 19 for the new headquarters of the Kentucky Nurses Association pictured above. The building is located at 1400 South First Street in Louisville.

KMA Committees and Commissions for the 1967-68 Associational Year

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Maternal Mortality Study Committee

To Be Appointed

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[03:767]

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Closing of Hospital Reported By Menifee Co. Journal

The United Presbyterian Center in Frenchburg, which includes the Jane Cook Hospital and nursing home, will soon close, according to a recent article in the Menifee County Journal.

The article reports that a resolution which called for the closing of the Center was passed at a meeting of the Board of National Missions of the United Presbyterian Church, October 26 and 27.

The resolution stated in part that the Board "directs the General Department of Health, Education and Welfare to re-establish present residents with a minimum of hardship and to phase-out over a period of time the program of residential, nursing and acute-care at the Center." It is not known just when the Center, established in 1915, will close.

A Delinquent Account Is Finally Paid In Full

It took 22 years, but an anonymous former patient of a late western Kentucky physician recently paid a bill in full to the physician's widow. The unsigned note accompanying the $25 cash payment stated:

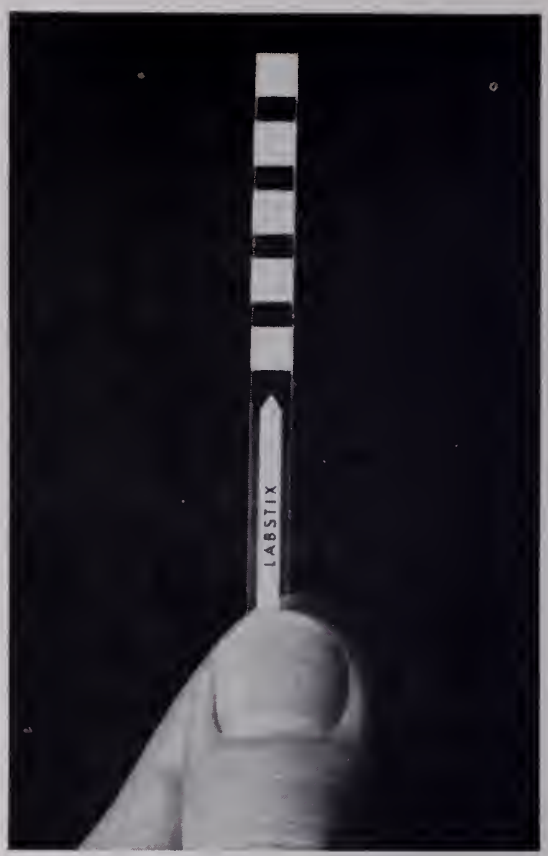
"Enclosed find $25 I owed Doctor Morris. I never intended to beat the debt. Just had a lot of bad luck."

The physician was Clifford J. Morris, M.D., Hopkins County, who died in July of 1945. He had practiced in the rural area of western Kentucky and Dawson Springs for 33 years. The identity of the slow but honest patient remains a mystery.

KPM Board Re-elects Dr. Robertson

Robert W. Robertson, M.D., Paducah, was re-elected president of the Board of Directors of Kentucky Physicians Mutual, the Blue Shield Plan for Kentucky, at a recent Board meeting.

Other officers re-elected include Garnett J. Sweeney, M.D., Liberty, first vice-president; Wyatt Norvell, M.D., New Castle, second vice-president; J. P. Sanford, Louisville, secretary and Branham B. Baughman, M.D., Frankfort, treasurer.



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Norton Seminar To Be Dec. 14

Harriet Pearson Dustan, M.D., a member of the research division of the Cleveland, Ohio Clinic Foundation, will be the featured speaker at the Tenth Annual Norton Postgraduate Medical Seminar December 14 at Norton Memorial Infirmary, Louisville. Doctor Dustan will discuss "Evaluation and Treatment of the Hypertensive Patient."

The seminar, entitled "Indications and Results of Various Therapeutic Procedures," will be jointly sponsored by Norton Memorial Infirmary and the Kentucky Chapter of the American Academy of General Practice, according to Lonnie W. Howerton, Jr., M.D., Louisville, program chairman. See the November issue of The Journal for complete information on the seminar.

Chest Physicians Elect Officers

The Kentucky Chapter of the American College of Chest Physicians elected Nathan Levene, M.D., Louisville, president for the coming year at a meeting in September during the KMA Annual Meeting in Louisville.

The Chapter elected Daniel Pickar, M.D., Louisville, vice president, and re-elected W. Buford Davis, M.D., Louisville, secretary-treasurer.

KMA Announces 8 New Members

Eight physicians have joined the Kentucky Medical Association according to the records of the membership department as of November 20.

The new members are Franklin Hoffman, M.D., J. Barrett Hyman, M.D., and Joseph G. Whelan, Jr., M.D., all of Louisville; Thomas E. Buie, Jr., MD., Frank M. Jenkins, Jr., M.D., George R. Park, M.D., and Leopoldo I. Pena, M.D., all of Lexington; and Rondall Hall Leslie, M.D., Salyersville.

WA Submits Resolution to House

The Woman's Auxiliary to the Kentucky Medical Association submitted a Resolution on Venereal Disease to their House of Delegates during the 1967 Annual Meeting in Louisville. The resolution endorses "the introduction of the factual and comprehensive teaching about venereal disease as an integral part of health education in every school system in Kentucky" and urges all responsible citizens to "lend active support to the control and eradication of venereal disease."

PMA Issues New Advertising Code

The Pharmaceutical Manufacturers Association issued a new "Code of Fair Practice" regulating the advertisement and promotion of prescription drug products on September 18, which replaces the earlier code issued in 1958. In announcing the new code, PMA President C. Joseph Stetler said that it had previously been submitted to the Department of Justice to assure compliance with federal laws.

K.Ph.A. Prepares for New Building

The Kentucky Pharmaceutical Association held ground breaking ceremonies October 2 at the site of the proposed building which will house the Association and the Kentucky Board of Pharmacy. The building will be erected on Highway 127 near Frankfort between the I-64 exit and the intersection of 127 and U.S. 60.

Following the ceremonies, a luncheon was held at the Holiday Inn at which Ralph J. Schwartz, president of the Association, and George Grider, Danville, president of the American Pharmaceutical Association, spoke.

In Memoriam

HERMAN H. MORGAN, M.D.
Maysville
1877-1967

Herman H. Morgan, M.D., a retired Maysville physician, died November 8 at the age of 90. Doctor Morgan, a 1903 graduate of the Eclectic Medical College in Cincinnati, practiced in Maysville from 1931 to 1963. Before coming to Maysville he had practiced in Ohio since 1910.

MILTON M. PHILLIPS, M.D.
Crab Orchard
1881-1967

Milton M. Phillips, M.D., 86, a retired Crab Orchard physician, died October 19 in the Ephraim McDowell Memorial Hospital, Danville, after a three-year illness. Doctor Phillips, a general practitioner, graduated from the Hospital College of Medicine, Louisville, in 1905.

PAUL F. RIZK, M.D.
Grayson
1898-1967

Paul F. Rizk, M.D., 70, a Grayson physician for 12 years, died September 29 at the King's Daughters' Hospital, Ashland. Death was attributed to a heart attack. Doctor Rizk graduated from the Middlesex University School of Medicine, Waltham, Mass., in 1931.

CHARLES OTTO TYDINGS, M.D.
Fern Creek
1878-1967

Charles Otto Tydings, M.D., 89, a retired Fern Creek general practitioner, died November 9 at his home. A 1905 graduate of the Louisville Hospital College of Medicine, Doctor Tydings had practiced since that time in Jefferson and Bullitt Counties until his retirement in 1959.

Primary Intracranial Extradural Abscess
(Continued from page 1187)

ondary to sinus disease. However, there was no epidural abscess in Pennybacker's[7] series of brain abscesses secondary to frontal sinusitis. The venous communications between the dura and brain have been implicated as probable routes of infection[5].

Summary

A case of primary frontal extradural abscess causing neurological deficit is presented. The theories of etiology and characteristic angiographic appearance are discussed.

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(Continued from page 1191)

zation of this structure as well. The thrombotic and micro-embolic complications of indwelling vascular catheters, as in V-J shunts, may limit the duration of easy access to renal vascular structures.

A fourth area for radiologic diagnostic activity is in the experimental field. Knudsen and associates[3] have studied rejection in canine renal allografts using Thorotrast. The features shown in human rejection by Alfidi were confirmed; in addition, intraluminal venous filling defects were noted and occurred prior to other radiographic and laboratory abnormalities. These resulted from focal subintimal round cell proliferation. Review of the illustrations of the venogram in Alfidi's paper suggests that minor irregularities were present in the lumen even though no major thrombosis was present.

Knudsen and his associates utilized Thorotrast because it passes through the kidneys and does not get excreted as do the 100 percent clearance substances used for angiography. Because of its radioactivity and storage in the body, Thorotrast cannot be used in humans; however, Cherigié et al[2] has been able to show renal veins and arteries in dogs using a suspension of micro-drops of opaque oil. The risk of embolization is real, but the advantages of contrast materials which pass through capillary phases and subsequently accumulate in veins to a degree permitting visualization are such as to warrant further research in this area.

As further experiences accumulate, other avenues for research can be expected to appear. Meanwhile, the radiologist has available today tools which can assist his surgical and medical colleagues in the diagnosis, evaluation and management of patients whose lives may be prolonged by appropriate organ transplantation procedures.

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4. Kountz, F.L. and Cohn R. Reported in: *Hospital Tribune,* 14 Aug. 1967.

(Continued from page 1200)

fective, defensive, and even unethical about the kind of religion that waits until people are down and sick before they are approached about the claims of religious affiliation. This is not to say that patients do not of themselves begin to rethink their whole life commitment as religious persons during illness. They do. It is to say that the pastoral care of the sick is the *pastoral* care of individuals who are sick. It is not the *promotional* care of an institution that needs members, namely the church to which we belong. If we take good care of the pastoral needs of the person, these other things will be added in the Providence of God according to his design and not ours.

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Ronald D. Hamilton, M.D., an internist specializing in endocrinology, is now practicing in association with the Lexington Clinic. Doctor Hamilton graduated from the University of Louisville School of Medicine in 1963. He interned at St. Joseph Hospital, Louisville, and completed his residency training this year at Mayo Clinic, Rochester, Minn.

William L. Underwood, M.D., a pediatrician, is now practicing in association with the Lexington Clinic. Doctor Underwood graduated from Vanderbilt University Medical School in 1964. He interned at Vanderbilt University Hospital in 1964-65 and completed his residency training there and at the University of Kentucky Hospital in 1967.

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Dr. Mahaffey To Head Heart Assn.

J. Herman Mahaffey, M.D. was elected president of the Heart Association of Louisville and Jefferson County at its annual meeting October 5. Other physicians elected to office include William C. Buschemeyer, M.D., first vice-president, F. Albert Olash, M.D., vice-president, and J. Murray Kinsman, M.D., member-at-large of the executive committee.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 21, 1967

2. Title of Publication: THE JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION.

3. Frequency of issue: Monthly

4. Location of known office of publication: 3532 Janet Avenue, Louisville, Jefferson County, Kentucky 40205.

5. Location of the headquarters or general business offices of the publishers: Same as above.

6. Names and addresses of Publishers, Editor, and Managing Editor: Publisher—Kentucky Medical Association, 3532 Janet Avenue, Louisville, Ky., 40205. Editor—Walter S. Coe, M.D., 568 Medical Towers South, Louisville, Ky., 40202. Managing Editor—J. P. Sanford, 3532 Janet Avenue, Louisville, Ky., 40205.

7. Owner: Kentucky Medical Association.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages or other securities: None.

9. Paragraphs 7 and 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10.

	Average No. copies each issue during preceding 12 months	Single issue nearest filing date
A. Total No. copies printed:	3072	3100
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales:	74	79
2. Mail subscriptions:	2366	2366
C. Total paid circulation:	2440	2445
D. Free distribution including samples by mail, carrier, or other means:	412	420
E. Total distribution:	2852	2865
F. Office use, left-over, unaccounted, spoiled after printing:	220	235
G. Total:	3072	3100

I certify that the statements made by me above are correct and complete.

J. P. Sanford, Managing Editor

Robert J. Lehman, M.D., a Louisville psychiatrist, has closed his office in Louisville to accept the position of director of education in the department of phychiatry at the University of Louisville School of Medicine.

1967 CONSTITUTION AND BYLAWS
OF THE
KENTUCKY MEDICAL ASSOCIATION

Revised September 27, 1967

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such

methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.
(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.
(e) Student Members. Any student in an accredited

medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

Section 5. Every new active member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component society, and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which

there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurels, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year, the President-Elect succeeding to the Presidency at the expiration of his term as President-Elect. The Speaker of the House of Delegates, the Vice-Speaker, the Secretary and the Treasurer shall be elected for terms of three years, but no member shall be eligible for election to more than two consecutive full terms as Secretary or Treasurer. Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice-Speaker of the House of Delegates, or Trustee, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to

elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each

county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall pertorm such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the

Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

Upon the complaint of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cases for disciplinary action exist. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary, ad hoc, committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $75, except Active Members who devote all of their time to teaching or research and have no private practice, $50.00; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.



Answers To Your Questions

About Blue Shield

Q. Is there any way for a Kentucky physician's office to obtain out-of-state Blue Shield forms without writing to each state Plan?

A. Most Blue Shield Plans will accept the Kentucky Blue Shield form when properly completed. If not, they will send you one of their forms.

Q. Why can't Kentucky Blue Shield combine all of its participating physicians' schedules of allowances into one manual?

A. A project to combine existing manuals into one has been proposed for completion in 1968, if feasibly possible.

Q. How often does Kentucky Blue Shield make payment to physicians for claims filed?

A. Weekly. Usually doctors' checks are mailed each Friday unless complicated by a holiday.

Q. How long does it normally take for Kentucky Blue Shield to process and pay a properly completed physician's service report?

A. Normally seven to ten days. Service reports received on Monday morning, not requiring additional information or investigation, are paid on Friday of the same week.

Q. How should a new physician go about getting a Blue Shield personal payment code number?

A. Request by letter addressed to Mr. Robert L. McCracken, Manager Blue Shield Claims, 3101 Bardstown Road, Louisville, Kentucky 40205. Send Kentucky state licensure number and exact address to which checks are to be mailed.



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

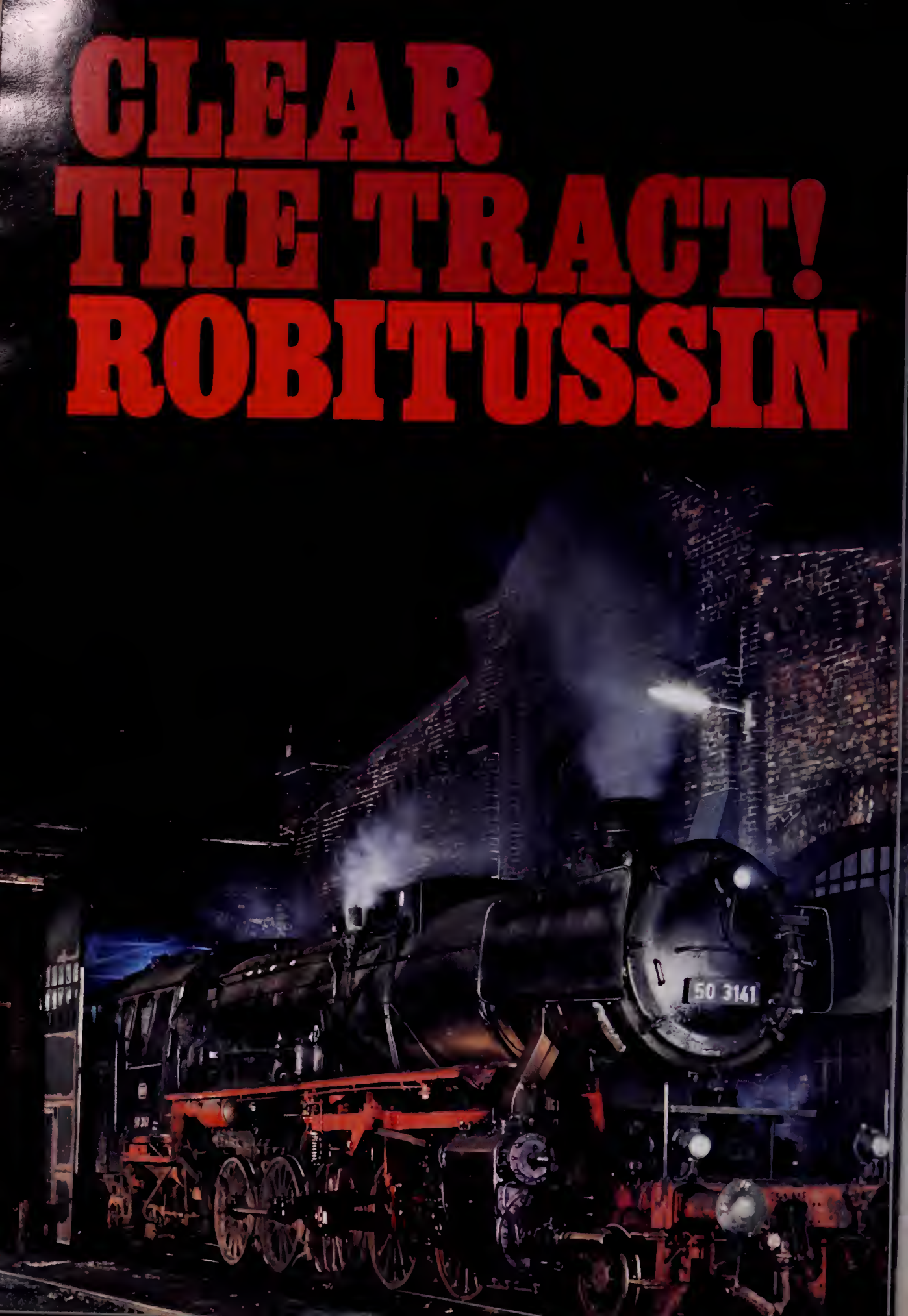
For acute, non-specific diarrheas **Donnagel® -PG** (Donnagel with paregoric equivalent). Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children. See product literature before prescribing.

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All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
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Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
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Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
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Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

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If it doesn't work in a week, forget it.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, ex-

In rheumatoid arthritis, Butazolidin alka needs only a week's trial. If it doesn't work in a week, forget it.

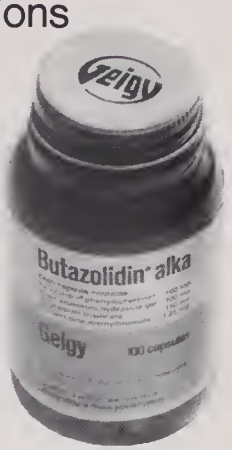
A short trial period may spare patients weeks of discomfort. That's one reason why Butazolidin alka seems a good choice when aspirin fails.

It's not for every patient. Check carefully the Contraindications, Warning, and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

You'll know quickly if it works.

And most of the time, it will.



foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules or tablets daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules or tablets daily; response is often achieved with 1 or 2 capsules or tablets daily.
6509-V(B)R2

For complete details, please see full prescribing information.

Butazolidin® alka

Capsules: phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Also available: Butazolidin®, phenylbutazone: Tablets of 100 mg.

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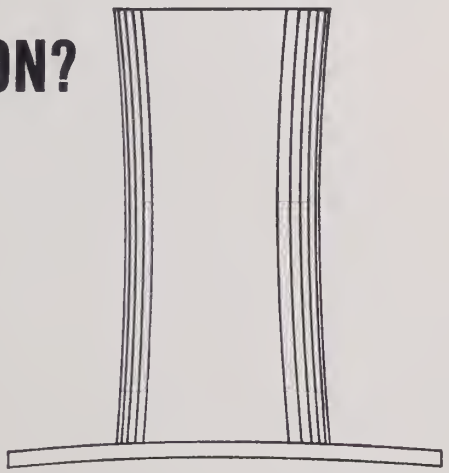
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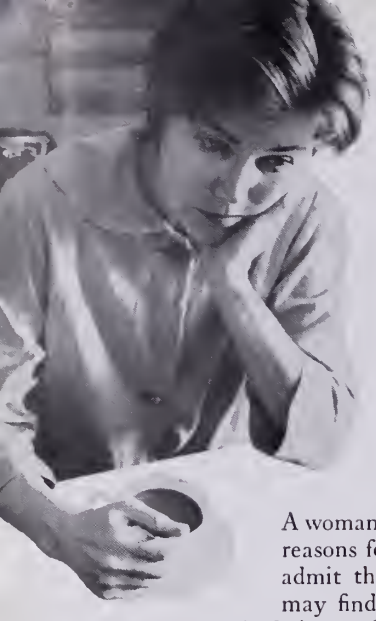
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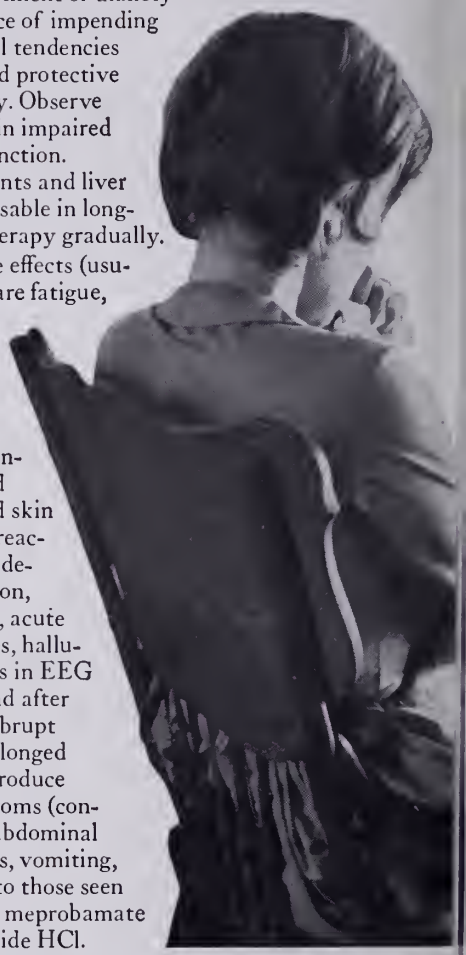


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Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects–particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.



Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage: *Adults:* Mild to moderate psychoneurotic reactions, to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 1 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 2 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm wit cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatr patients:* 1 or 2 mg/day initially, increase gradually as neede and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 m bottles of 50 and 500.

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useful for the relief of psychic tension with associated depressive symptoms

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